NECROGRAPHY: A NEW CORPUS OF DEATH TELLING FROM THE PHYSICIAN'S PERSPECTIVE

by

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ABSTRACT

Physicians are routinely exposed to dying patients and death, although some encounters are emotionally and existentially problematic, creating problems on two levels. Individuals are taught through medicine's hidden curriculum to detach from patients at the end-of-life, which can conflict with their personal values and result in moral distress. Institutionally, medical discourse does not officially encompass personal reflective writing, although it has been cited as potential remediation. This study uses discourse analysis, narrative discourse analysis, and rhetorical genre theory to critically investigate 126 physicians' personal articles recounting experiences from their postgraduate training with dying patients, which have been published in 14 general medical journals over 47 years. Findings disclose six rich discoursal features that distinguish physicians' personal discourse as rhetorical: repetition, metadiscourse, emotive language, euphemisms, metaphors, and narrative. Analysis of narrative, the dominant feature, reveals that physician-authors consistently use personal writing to resist the hidden curriculum. Recurring themes--challenges to medical enculturation, counter-cultural medical practices at the end of life, and reincorporation of humanistic values--represent genre knowledge critical to an ethical practice of medicine. Therefore, physicians' personal discourse warrants rhetorical recognition as another genre of medical discourse, which I provisionally call *perspective writing.* Texts that focus on dying and death constitute the subgenre *necrography.* Findings from analysis

of *necrography* using a combined method of material rhetoric, critical rhetoric, and phenomenology further reveal that narrative enables physician-authors to relate to the corpse in terms of *kairos*. They reconceptualize death as a critical time in which they can reconnect to the human body of the dead person and to their own mortality, humanizing the patient and themselves. I propose this representation of the corpse as the *kairotic* body, a theoretical model that expands upon other theories of the power of the unruly body. Rhetorical recognition of the genre of *perspective writing*, and by extension *necrography*, would substantiate the value of an existing body of medical writing as a significant and beneficial corrective to moral distress. *Necrography* especially provides new, crucial perspectives on dying that may contribute to the demedicalization of death in the medical profession and ultimately, in American society-at-large.

"To commit to journeys of compassion challenges me to remain fully aware of the experience—the suffering, the distress—of the person with a life-threatening illness who may be near the end of life whether or not I have an expectation of relieving the cause….In the end, I have come to understand that those are the times when I need to be less of a physician in order to be more of one."

Larry D, Cripe, M.D.
"Giving Up," *JAMA 301,* 17, 1748

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CHAPTER 1

INTRODUCTION

Most Americans have not personally witnessed the dying process. They have not experienced the sight, sounds, and smells of a body that can often be overwhelming as it transforms at death into a corpse. Since the latter half of the 20th century, dying, even of a loved one, usually takes place at a distance in an institutional setting (CA Healthcare Foundation, 2012), rendering death an abstract event. One segment of American society, however, is repeatedly exposed firsthand to dying and death: health-care professionals. In particular, physicians have been given legal as well as medical responsibility to certify all deaths occurring in hospitals. Physicians *pronounce* the end of a human life by touching, listening to, and observing the body of the deceased person; they *call* the time that is officially recorded as an individual's final minute of human existence. Thus, physicians experience an intimacy with death that few others do--though not necessarily by personal choice. Professionally, they are required to manage patients' dying, to *handle* death. Yet professionalism also mandates that physicians distance themselves emotionally, psychologically, and existentially. Any affective or visceral responses to patients' dying are regarded as professionally "extraneous" (Meier, Back, & Morrison, 2001, p. 3007). Nonetheless, physicians cannot always confront death in this idealized detached manner. They grieve, and they cry. They react with shock and anger, fear and

loneliness, sometimes relief (Zambrano & Barton, 2011). Even for oncologists, who expect in their specialty to routinely experience death since many of the patients they care for are terminally ill, grief is "pervasive, sticking to the physicians' clothes when they [go] home after work and slipping under the doors between patient rooms" (Granek, Tozer, Mazzotta, Ramjaun, & Krzyzanowska, 2012, p. 964). Further complicating physicians' personal responses to dying are the accompanying feelings of frustration, self-doubt, guilt, and powerlessness when patients under their care die (Bradley & Brasel, 2008; Granek, Tozer, Mazzotta, Ramjaun, & Krzyzanowska, 2012; Meier, Back, & Morrison, 2001; Whitehead, 2012). These negative affective responses, although related directly to their professional role, are likewise silenced, resulting in stress, burnout, cynicism, and depression in physicians, which has been documented over many years (Coulehan, 2005; Granek, Krzyzanowska, Tozer, & Mazzotta, 2012; Kleinman, 1988; Meier, Back, & Morrison, 2001; Redinbaugh et al., 2003; Tucker, 2009; Whitehead, 2012).

Of particular concern is how this "conspiracy of silence toward emotion" (Redinbaugh et al., 2003, p. 188) impacts physicians-in-training. Residents from multiple specialties experience anxiety, depression, and post-traumatic stress disorder (Van Allen, 2010) in response to problematic encounters with dying patients. Trainees engage in maladaptive coping behaviors (Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Vallurupalli, 2013), including suicide (Sinha, 2014). Although humanism and altruism are underscored in the institution's formal curriculum, medical students and postgraduate medical students—interns, residents, and fellows--learn more about the practice of medicine from physician role models in what has become known as medicine's "hidden curriculum" (Hafferty, 1996; Hafferty & Franks, 1994; Hundert, 1996): the informal

teaching that occurs in patient rooms, hospital hallways, and outside clinics. Here, physician-trainees learn what are and are not appropriate attitudes, beliefs, values, and behaviors in the culture of medicine. They learn that death is failure resulting directly from their inability, their inadequacy to successfully carry out medicine's technological imperative (Callahan, 2000; Chapple, 2010; Dubler, 2005; Dugdale, 2010; Hardwig, 2009; Kaufman, 2005; Lynn, 2005; McCue, 1995; Scott, 1981; Whittington, 2011), which demands that physicians do all they can to prolong life.

Advances in medical technology have made it increasingly possible in the past 70 years for physicians to delay death, a possibility that has morphed into the cultural expectation in America that death *should* be staved off. Physicians are expected to postpone or temporize death, treating it like a disease state rather than a natural and inevitable event in human life. This practice has been referred to as the medicalization of death (Conrad, 2007), an instance of the larger medicalization of American society (Clark, 2006; Conrad, 2007; Lupton, 2003). While the profession of medicine has played a significant role in promoting medicalization and the resulting power it gives to its members, medicalization is more accurately "a form of collective action" by multiple social actors (Conrad, 2007, p. 9). The personal effects of medicalization, epitomized in the technological mandate, are evident in the way death is (not) handled by physicians: as professionals, they are enculturated to disassociate themselves from their personal responses. The result is "ethical erosion" (Billings, Engelberg, Curtis, Block, & Sullivan 2010, p. 320), ranging from "innumerable clinical-moral qualms" (Kaufman, 2005, p. 41) to moral distress, which has been described as "negative feelings that arise when an individual believes he or she knows the morally correct response to a situation, but cannot act because of hierarchial or institutional constraints" (Loomis, Carpenter, &

Miller, 2009, p. 107). Physicians suffer moral distress when their personal values and beliefs conflict with professional ones imposed by the institution of medicine that itself has been medicalized. Especially vulnerable are physicians-in-training who are not yet fully enculturated and lack not only medical expertise but the skills and experience to detach themselves from contradictory situations. In terms of death, this means that trainees, modeling those higher on the medical hierarchy, deny the power of death so as to deny the existence of their own moral suffering. They avoid the essential questions death raises about mortality and the nature of being human; a situation which raises the specter that, through medical education's enculturation process, the institution of medicine is actually dehumanizing the very professionals it is training.

In response, American medical schools have revised curricula. Beginning in the 1970s, courses in medical ethics were offered; in the 1980s, medical humanities; and in the 1990s, courses on professionalism, which continue to proliferate (Birden et al., 2013; Coulehan, 2005; Hafferty & Frank, 1994). A recent review of literature on professionalism, defined variously as an ideology based on humanistic values to an ethos based on humanistic behaviors, concluded that after 20 years, there are still no "validated, productive, replicable teaching methods for professionalism" (Birden et al., 2013, p. e1263). What was found effective, though, was an emphasis on personal reflection. Indeed, self-awareness was identified as a critical though missing component of medical education by Frederic Hafferty and Ronald Franks in their seminal 1994 article on the hidden curriculum and was reiterated by Hafferty (2006) 11 years later in *The New England Journal of Medicine*. During the intervening years, the need for physicians as well as physicians-in-training to engage in personal reflection has been repeatedly and consistently voiced (Branch et al., 2001; Davidoff, 2008; Fish & de Cossart, 2006;

Kearney et al., 2009; Lie, Shapiro, Cohn, & Najm, 2010; Lomis, Carpenter, & Miller, 2009; Meier, Back, & Morrison 2001; Rhodes-Kropf et al., 2005). In particular, writing narratives has been singled out as an effective means of increasing physicians' self-awareness (Charon, 2001; Coulehan, 2005; DasGupta & Charon, 2004; Doukas, McCullough, & Wear, 2010; Greenhalgh & Hurwitz, 1998; Ragan, Mindt, & Wittenberg-Lyles, 2005). When the topic addressed is death, however, medical educators and researchers have found the literature lacking. Physicians' affective responses to dying patients have been quantitatively and qualitatively identified (Artiss & Levine, 2007; Meier, Back, & Morrison, 2001; Serwint et al., 2006). Yet as recently as 2011, researchers claimed that "little is known about how [physicians] approach a dying patient and what impact it has in their lives" (Zambrano & Barton, 2011, p. 827).

From the Physicians' Perspective

In this dissertation, I will prove that physicians not only have thought about the place and meaning of death in the practice of medicine; they have written and published articles for more than 40 years in prominent medical journals, including *The New England Journal of Medicine* and the *Journal of the American Medical Association* (*JAMA*), about their personal experiences with dying patients and death. These texts, actively solicited and peer-reviewed by medical journals, have been largely ignored, since they lack rhetorical recognition and stature. My central argument is that physicians' personal writing should be formally recognized as a genre of medical literature, because it is a valuable though overlooked existing resource that addresses the moral distress physicians experience and struggle with as trainees and professionals.

In medical journals, physicians' subjective accounts of their professional experiences are referred to as "personal essays," "reflections," "vignettes," and "personal narratives," distinctly literary labels that situate the discourse within the hierarchy of English literature (Hawkins, 1999; Wear & Jones, 2010). *The AMA Style Guide* (2007) refers to the discourse of physicians' personal writing as an "other" type of medical writing, the last of eight types listed in hierarchial order; they are not regarded as *praxis* literature (Ainsworth-Vaughn, 2001), discourse directed toward the practice of medicine as an applied science. Instead, the articles are relegated to special journals sections with nonscientific, thus ancillary titles such as "A Piece of My Mind" (*JAMA*) and "Reflections" (*New England Journal of Medicine*).

I contend that that the discourse of physicians' personal texts is directly and critically related to the practice of medicine. It constitutes physicians' social responses to the hidden curriculum: The texts resist and/or disrupt the professional silencing of personal emotions and moral beliefs imposed by the institution of medicine. In terms of dying and death, physicians' personal writing accounts for as well as recounts their experiences. The discourse tells how and why physicians-in-training responded as they did, challenging, opposing, and even revolting against teachings of the culture of medicine when they confronted problematic patient care situations at the end of life. The discourse serves as genre knowledge (Berkenkotter & Huckin, 1995): It provides critical information about the profession of medicine; disciplinary knowledge that is necessary and vital to physicians and especially physicians-in-training striving to practice medicine as moral individuals through the integration of their personal and professional selves. In short, the discourse recounts medical practice from the perspective of physicians and

their real-life experiences.

Accordingly, I propose that the medical discourse represented by physicians' personal writing be recognized as a genre that I call *perspective writing.* At levels of individual texts as well as discourse, the writing fulfills the definition of *perspective* in its adjectival form: the articles recount scenes—clinical experiences and patient encounters of individual physicians—relative to a particular time and from a personal distance. Furthermore, perspective writing can be aligned theoretically with perspectivism, a philosophical position that recognizes the validity of an individual's own perception and the impossibility of an objective experience.

A New Corpus of Death Telling

To argue that *perspective writing* is a social response to the hidden curriculum, I draw upon rhetorical theory, namely critical discourse analysis and rhetorical genre theory (Berkenkotter & Huckin, 1995; Miller, 1984, 1994), to critically examine a corpus of physicians' personal texts focusing on death. I have collected more than 120 personal writings by physicians about their clinical experiences with dying patients that are published in general medical journals, which I propose as a subset or subgenre of *perspective writing* to be called *necrography.* The term combines the Greek word *necros*, meaning "corpse," with *–graphy*, from the Greek word *graphein*, "to write." I have narrowed my critical investigation of *necrography* to physicians' accounts from their years as postgraduate medical trainees in response to repeated calls to more adequately prepare interns and residents to care for patients at the end-of-life

(Larson & Tobin, 2000). [1] Thus, the first of three research questions guiding my investigation is:

> ***RQ #1:*** *How does necrography, a subset of perspective writing, function as a rhetorical response to the exigency that death poses for the practice of medicine by physician-trainees?*

By using a rhetorical lens, I reframe the dynamics of patient care at the end of life in terms of a rhetorical situation (Bitzer, 1968). I identify a confluence of medical, social, and political events that have occurred within the past 70 years; a heretofore unrecognized rhetorical situation within medicine. I hypothesize that the new medicalized conception of death, which troubles physicians personally and professionally, is a medical exigence, which necessitates a discursive response from practitioners and trainees.

Narrative: A Personal Account That Recounts in Deep Time

When physician-authors discursively recount their experiences as trainees attending to dying patients, they are narratively ordering the events that comprised their experience (Johnstone, 2008). Therefore, I propose that narrative is the key defining feature of *necrography* and by extension, *perspective writing.* A narrative recounts what happened by (re)ordering events in time, thereby enabling the author to uncover new meaning in the telling of the experience. Reflection collapses the strictures humans place upon time—past, present, and future—because in recollection, the past is brought forth

[1] Although the study corpus is limited to personal writings by physicians, *necrography* can be authored by others inside the health professions (e.g., nurses, physical therapists, medical students) as well as individuals outside medical culture (e.g., family members of and caregivers to the chronically critically ill) who publish in professional journals focusing on medicine and health.

into the present, spiraling into the future that also becomes present. This understanding of time explicitly contradicts medicalized time, which is measured as a progressive chrono-logical ordering (Kaufman, 2005). With their narratives, physician-trainees oppose the imperative of medical time endorsed by the hidden curriculum. In its place, I suggest, physicians are experiencing and describing the "deep time" that Paul Ricoeur posits in his theory of narrative and time (1980, 1991a, 1991 b). Particularly in his later works, the French philosopher argues that personal identity is composed through narrative and time, which I find especially relevant to physicians' personal writing. I hypothesize that through narrative, physician-authors resituate themselves outside the culture of medicine where they can reflect on their experiences and find new meaning in deep time, which is a unified sense of time where the past and future are experienced in the present. Freed from the constraints of the hidden curriculum and its model of the physician as detached professional, physician-authors re-envision their identity as moral human beings. Thus, narrative elucidates not only how physicians resist the hidden curriculum but equally important, the reasons why: the taken-for-granted values and beliefs that underlie the culture of medicine. Accordingly, my second research question is:

> ***RQ #2:*** *What does the genre knowledge articulated by necrography tell us theoretically about medical practitioners' behaviors and attitudes toward death?*

The Corpse as *Kairotic* Body

When physician-trainees write about their near-death experiences, recounting how they attended or failed to attend to patients during their dying, they are performing "radical reflection upon lived experience" (Toombs, 1993, p. xiii). From a

phenomenological perspective, the physician-trainee "sets aside any theoretical commitments derived from the natural sciences" (p. xii) so as "to focus upon the lived experience of embodiment" (p. xiv), and in this case, the bodies of both patient and physician. Critical analyses of the study corpus, I hypothesize, will show how necrography allows for the re-presentation of dying bodies while rhetorically fleshing out the materiality of physicians as embodied practitioners, an aspect of their being that is silenced by medicine's continued, though often tacit reliance on the division between mind and body.

In addition to phenomenological theories of the body, I draw upon theories of material rhetoric to open up physicians' bodies of text to perceive new understandings of death. From this theoretical vantage point, rhetoric focuses on relationships, not facts: "It is a medium, a bridge among human beings" (McGee, 1982, p. 27); rhetoric is "'material' by measure of human *experiencing* of it" (p. 29; italics in original). More recently, Debra Hawhee in her investigation of material rhetoric in ancient Greece interrogates time, offering a complex and nuanced definition of *kairos* "as opening, as weaving, as timing, and most notably, as critical delimited places on the body" (2004, p. 67). She relates *kairos* as embodiment specifically to the practice and performance of medicine. In ancient times, physicians employed "bodily *kairos*—momentary, embodied perception of somatic symptoms—to make the right diagnosis at the right time" (p. 70); a process that simultaneously drew upon physicians' bodies and minds. But *kairos* can be also be interpreted in a reverse sense in which "the rhetor opens him or herself up to the immediate situation, allowing for more of an exchange" (p. 71), which is referred to as "kairotic inspiration."

I argue that immediately after death, a person's body is transformed into the *kairotic* body. The corpse as the *kairotic* body becomes a material and metaphorical opening--a critical opening through which we can interrogate what it means to be human. We can examine physicians' personal writing about their encounters with newly dead bodies, listening for the authority of their voices as medical professionals entrusted by society to do all they can to prolong life at a time when they no longer can do so. Equally important, we can listen to the corpse and how it reverses the power differential in the traditional doctor-patient relationship: The corpse gains agency and becomes the rhetor. Thus, the third question guiding my research is:

> ***RQ #3:*** *How does the representation of the dying/dead body in necrography function in terms of material rhetoric as the kairotic body with particular significance for the doctor-patient relationship?*

Such a reading is not as transgressive as it might initially seem. Within the culture of medicine, we find support in scholarship by physicians and scholars whose work I reference. Arthur Kleinman, in explaining the origin of his notion of body-self, states that "[r]reading the Hippocratic medical texts suggest that, although some of the conceptions are quite different, a similarly integrative, dialectical view of the body, self, and world was found in ancient Western society" (1988, p. 12). In her theory of medical knowledge as narratively structured, Kathryn Montgomery Hunter says medical knowledge "is phronesis—practical and applied knowledge—and not a matter of scientific principle alone" (1991, p. 27). More recently, bioethicists have reinterpreted *phronesis*, the Greek word meaning practical and applied knowledge, in terms of medical practice (Kuczewski & Polansky, 2000). My research expands upon this scholarship by

focusing on physicians' personal relationship to dying/dead bodies, which has not been critically explored.

Death Telling as Life-Giving: Contributions to Scholarship

Re-envisioning death as a shift in agency from physician to corpse not only would invert the power dynamics of clinical encounters between doctor and patient; it would bring into view a new dimension of medical discourse in which rhetoric could help reconstruct the doctor-patient relationship as conciliatory, rather than competitive, and provide new ways of actualizing shared-decision making. Findings from this dissertation have the potential to contribute to and expand rhetorical scholarship in disciplines that investigate the doctor-patient relationship: health communication, medical rhetoric, writing studies, narrative studies, medical sociology, and medical education, in addition to the interdisciplinary field of medical humanities. Indeed, the cross-disciplinary approach I take in this dissertation is intended to directly respond to the call for rhetoricians "to explore new paths… locate, discover, stumble over, and then open up silences" (Glenn 2004, p. 151), particularly "sociocultural silences" (p. 17). I suggest that medicine, an institution that helped promulgate medicalization but has fallen subject to its social force, is a culture whose silences need to be rhetorically opened.

At the beginning of the new century, changes in American demographics also are making it crucial for medicine and society-at-large to examine silences surrounding dying and death. The first cohort of "baby boomers," Americans born after World War II and up through the early 1960s, turned 65 years old in 2011. While the aging generation characterizes itself as physically and intellectually active, socially productive, and ever youthful (Scannell, 2006; Wadley, 2010), clinicians offer a decidedly different

perspective. Americans 65 and older are "uniquely burdened with illnesses" (Mueller, Hook, & Fleming, 2004, p. 554); they account for most deaths. As baby boomers age, many will lose their cognitive capacity to make critical decisions regarding their end-of-life medical care (Libow, 2005). Already physicians have identified "chronic critical illness" (Lamas, 2014): a condition of mostly elderly patients who are resuscitated but can never be taken off mechanical ventilation, so remain hospitalized. The temporization of their deaths is a new example of medicalized dying. I suggest that physicians' personal writing—*perspective writing*—has the potential to help begin difficult conversations about the dying process in America. *Necrography* tells how neophyte physicians learned to draw closer to dying patients and to relate to them as persons and not simply as patients. Narratives of their personal experiences may help health-care professionals and lay persons alike begin to reconceptualize abstract notions about dying and replace denial of death with recognition of dying as a crucial and natural life event. Just as *necrography* shows how physicians recompose their personal identities, perhaps it will demedicalize death for others, inspiring death with renewed humanity.

Now, I argue, is the time for the profession of medicine to come to terms with dying and death; to see the intertwined questions of how and when we die, and the meaning of death from a perspective that affords practitioners the time and space to draw closer to the dying body; to understand how the corpse, and the suffering and compassion it engenders in the bodies of the living, does *matter*.

Overview of the Dissertation

In Chapter 1, my goal has been to introduce physicians' personal writing and show how the discourse is situated outside medical literature, even though the writing is

published in professional medical journals. Formal recognition will validate knowledge about the practice of medicine that is conveyed in the discourse of physicians' personal writing, a finding that has the potential to expand medical education and epistemology. Furthermore, recognition will bring awareness to physicians' texts about their experiences with end-of-life care as a professional resource, particularly medical attention to the newly dead body, which has not been critically analyzed through a rhetorical lens.

In Chapter 2, I review literature on several key concepts, providing both background and context for my arguments. I begin with an historical overview of how death has been understood in Western culture; attitudes toward dying and beliefs regarding death that have strongly influenced the culture of medicine and physicians' practice. I discuss medicalization and its impact on patient care at the end of life; I also review literature on the hidden curriculum. Both have been strong determinants of how medical professionals attend to dying patients. Finally, I give an overview of narrative and medicine, discussing how narrative theory has been applied to medical education and medical practice.

The purpose of Chapter 3 is to present the research methods I used at different stages of my analysis. The predominant method is discourse analysis (Barton, 2002), followed by narrative discourse analysis (Johnstone, 2008; Labov, 1999; Labov & Waletsky, 1967) and rhetorical genre theory (Berkenkotter & Huckin, 1995). The latter two are closely aligned methodologically and theoretically with discourse analysis. For the final stage of analysis, I drew upon material rhetoric (Hawhee, 2004; McGee, 1982) to re-examine the newly dead body and derive new insights into the rhetorical agency of

the corpse, which lead to new ways of understanding death in the context of lived experiences.

In Chapter 4, The Matter of the Corpus, I trace medical, social, and political events that occurred primarily in the United States in the period after World War II to show how they came together to form a "rhetorical situation" (Bitzer, 1968) for the institution of medicine. I explain how death becomes a medical exigency and physicians' personal writing, the social response. At the individual level, physicians are publicly disclosing their personal responses to dying patients and death, responses that often conflict with tenets of the culture of medicine. At the institutional level, medical journals have created new rhetorical spaces where editors invite and publish only nonscientific writing. Although marginalized by journals as literary and ostensibly valued less than original research, these personal texts nonetheless emerge within the medical discourse community as a new type of professional literature.

In Chapter 5, Discourse Analysis: Dismembering the Corpus, I critically examine results of my discourse analyses of the 126 individual texts that form the study corpus to support my argument that physicians' personal articles are rhetorical. I identify six "rich" discoursal features (Barton, 2002) that distinguish physicians' personal writing from other discourse in medical journals, notably an extensive use of metadiscourse through which physician-authors become rhetorical agents explicitly telling readers how to understand what they write.

In Chapter 6, Narrative Discourse Analysis: The *Telling* of Death Telling, I address how physician-authors use narrative, the dominant rich discoursal feature, which reveals *why* trainees are compelled to tell about their encounters with dying patients and *what* the point is of their telling. I identified 11 types of routine medical procedures and

situations related to the care of patients at the end of life, which have not previously been parsed out. Using narrative preconstruction as a theoretical framework (Labov, 1999), I discuss how these complicating actions became uncommon, thus remarkable. Each procedure or situation presents a moral conflict between the personal values of physicians-in-training and the professional constraints imposed upon them by medical enculturation. Trainees respond by challenging and resisting those constraints, even subverting the culture to which they have sworn to uphold. Thus, I argue that the personal experience narratives of physicians serve as oppositional narratives. They are discursive insurrections against the institution of medicine through which physicians revolt against idealized role models and especially the ways the institution has medicalized time. Physician-authors oppose the practice of temporizing or postponing death through medicine's technological imperative. Instead, physicians use their personal authority gained through reflection and recollection to assert a new rhetorical use of narrative in medicine.

In Chapter 7, Rhetorical Genre Analysis: Perspective Writing as *Another* Genre, I build upon my argument regarding oppositional narratives by identifying at the level of discourse recurrent themes related to patient care at the end of life: resistance to a prevailing culture of blame; objections to fears attached to subjectivity and affective expression; and contestation of medicine's amoral enculturation. I contend that these discoursal themes constitute the quotidian, though culturally unsanctioned knowledge of the practice of medicine, which substantiates the central argument of this dissertation: that physicians' personal writing be recognized as another—a different, thus additional—genre of medical literature. Recognition of the genre's valuable disciplinary knowledge brings to light a revolutionary practice of patient care at the end of life. When physician-

authors reflect upon their experiences with dying patients, they stand outside medicalized time where they gain a new perspective on their practice. They recollect values and attitudes nominally recognized in professional oaths; they return to ancient Greek role models of physician-healers, *iatros* (Bartz, 2000) brought to mind when they recite the Hippocratic Oath. Through their personal narratives, physician-authors put these moral values back into practice. Among the most revolutionary practices, I argue, is recognition of the newly dead body as the *kairotic* body (Hawhee, 2004): a critical opening on multiple levels. Rhetorically, understanding the corpse as the *kairotic* body elucidates the power dead bodies have over physicians. The corpse inverts the doctor-patient relationship. Though disempowered medically, physicians-authors describe newfound power as human beings; death enables them to relate to patients on fundamentally moral and mortal terms. Thus, narrative presents to physicians a new way of knowing; a new epistemology grounded in *phronesis* (Montgomery, 2000), practical wisdom that centers on healing gained through real-life experiences with death.

In the concluding chapter, I summarize my study, note limitations, and highlight primary contributions to medical rhetoric, rhetorical genre theory, and material rhetoric. On a practical level, I discuss how the research impacts medical education and training. Equally important, I suggest how the recognition of a new genre of medical discourse eventually may influence societal discussions. The renewed practice of medicine that is revealed through physicians' personal narratives has the potential to radically alter how the culture of medicine and, ultimately, American society understands dying and death in the 21st century.

CHAPTER 2

REVIEW OF THE LITERATURE

This dissertation is a rhetorical investigation of the power of discourse in the institution of medicine. It examines how discourse constructs physicians' knowledge of and relationship to the human body, the material and conceptual focal point of the practice of medicine. Without the body, there would be no doctor-patient relationship. Persons only become patients when their bodies require the attention of physicians who are trained to provide insight into the body, professionals who have access to scientific and medical knowledge that they use to prolong and sustain the lives of patients. Even though the institution of medicine has in recent years committed to a shift in the dynamics of the doctor-patient relationship by publicly advocating shared decision-making, physicians are empowered by the institution of medicine with privileged, disciplinary discourse that allows them to treat and control the body. The exception is the dying body and the dead body; both disrupt the institutional narrative that denies death. Physicians-in-training especially find themselves unprepared and disempowered by the dying body. Assured by medicine's hidden curriculum that professional physicians can affectively detach themselves from the bodies and the persons of dying patients, trainees respond by challenging, resisting, and subverting the institutional discourse. They write and publish subjective accounts of their experiences in medical journals in which they re-

naturalize death, repersonalize patients, and rehumanize themselves. Thus, my goal in this study has been to interrogate the oppositional discourse physicians-in-training create to morally empower themselves as individuals *and* physicians.

My project draws upon scholarship in communication, particularly rhetoric, material rhetoric and body studies, and critical rhetoric, and health communication. I begin my review of literature with a discussion of Michel Foucault whose theories on discourse, power, and knowledge are foundational to communication. His investigation into the history of the medical clinic lays the groundwork for understanding how medical knowledge has been constructed by discourse that renders the body and death abstractions; how medicalization empowers the institution of medicine but disempowers individual physicians; and how physicians-in-training subversively wield discourse in response to medicine's hidden curriculum.

Foucault: Discourse, Knowledge, and Power

The theories of philosopher Michel Foucault are among the most influential in critical rhetorical studies as he challenges traditional notions of discourse. Rather than objectifying discourse, historically understood as the ways in which information is thought and then simply expressed, Foucault directs attention to discourse as a construction of and relationship to power. With discourse, language and practice are intricately entwined, which enables and limits conditions of existence. Owning a discourse— that is being in a discourse — allows privileged access to information that others do not or cannot have. Discourse constitutes knowledge, which empowers those who belong to it; they control knowledge, which they can use to discipline others. In

other words, Foucault posits discourse as a construction inextricably related to power and knowledge. He is not objectifying discourse as a construction in the positivist tradition. Rather, he maintains that we experience the world *through* discourse; through language as a construction that we are used to thinking with. Thus, human thought and experience are bound to discourse. Meaning is found in the discourse that is the experience; the language we use to construct our experience. Truth is the discourse that is our experience; it does not exist in an object independent of discourse. The meaning of the discourse, however, is strongly influenced by the context in which it is experienced, the social and cultural environment comprised of hierarchies of knowledge and power. Analyzing discourse from this theoretical stance invites questions about who is writing or speaking, their position, how they might control the discourse, and for what gain?

In his theories, Foucault proposes four principles, three of which I review in the context of the culture of medicine with references to *The Birth of the Clinic: An Archaeology of Medical Perception* (1994/1973). In that work, Foucault's most relevant to this dissertation, he employs the reversal principle to examine the discourse of medicine as it shifts focus from the human body to disease. Reversal is the reviewing of medical history from a critical standpoint that asks what information has been left out of the traditional account. In *The Birth of the Clinic,* Foucault limits his historical re-investigation to the late 18th century when pathological anatomy developed as a medical science, made possible through the dissection of the human body in the form of the corpse. Before then, physicians practiced medicine primarily through observing the body of the living patient, listening to the person's account of changes in his/her body, and relating this information to medical knowledge, which at the time was a system of

classification, "a nosological picture" (p. 4) of disease. Dissection literally opened the body to physicians who gained privileged access to the interior of the human body. What physicians could see and how they shaped relevant practices constituted a new kind of medical knowledge, a discourse that the medical profession owned. Pathological anatomy gave physicians new insight into the body and the discipline of medicine, new power over bodies, which gave rise to clinical medicine. The "medical gaze," made possible through dissection, redirected the physician from the "concrete body, that visible whole, that positive plenitude that faces him—the patient…towards…negatives, 'the signs that differentiate one disease from another" (p. 8). Further, death was resituated; it was no longer the natural endpoint of the biological body. The corpse became the space for the construction of discourse essential to knowledge of life.

Foucault's discontinuity principle identifies interruptions in traditional accounts where assumptions are disturbed. In terms of the medical gaze, the limitations of physicians' insight into the body are revealed: They can see only what they can speak, the discourse that constitutes their experience and their thought. Developments in medicine as an applied science are usually perceived as progress, a positive progression always moving to an increased knowledge that brings about an improved future. Foucault maintains that pathological anatomy limited medical knowledge, which gave a "strange character [to] the medical gaze" (p. 9) and the "endless reciprocity" (p. 9) of medical knowledge, as opposed to the forward-moving trajectory traditional history assumes. Physicians came to the dissected corpse with "a rational, well-founded body of medical knowledge"; however, "in order to *know*, [the physician] must recognize, while already being in possession of the knowledge that will lend support to this recognition"

(p. 9; emphasis added). What results is a reflexive and self-limiting relationship between physician and medical knowledge.

Finally, the principle of exteriority focuses on the meanings revealed on the surface of discourse that encompasses the context, as opposed to traditional notions of truth hidden in the depths of reality. It is in examining the situations that make discourse possible, which in medicine are the power relationships within the institution of medicine that reveal how knowledge is constructed and controlled. Foucault does not interrogate power relationships between physicians and patients in *The Birth of the Clinic*; his work does, however, lay groundwork for the investigation of this relationship from a new understanding of discourse, the body, and knowledge.

Omission of the Body and Denial of Death

The science of pathological anatomy that gave rise to the clinical practice of medicine rendered the body an abstraction and changed perceptions of death. To understand how both conceptions continue to influence medical education and practice, I review traditional understandings of each. I begin by reviewing historical conceptions of death that centered on recognition of the mortal body and acceptance of death as a natural and inevitable event. I follow with contemporary understandings of death as an abstraction constructed of ambiguous discourse, which allows Americans individually and collectively to deny mortality.

In Western cultures, the conception of death remained largely unchanged for centuries: It was the inevitable destiny of all human beings. Death was not feared as much as accepted as a natural occurrence. Dying was expected; the diseased and aging

body provided indisputable evidence. Mortality was a matter of time as stated in the Old Testament's Book of Ecclesiastes: "For everything there is a season and a time for every matter under heaven: …a time to be born, and a time to die" (Revised Standard Version). Rationalists also did not question how or when a person died: "'If you don't know how to die, never mind. Nature will instruct you how to do it there and then, plainly and adequately'" (Michel Montaigne quoted by Tucholsky, 2003, p. 210). Even midway through the 20th century, death was expected and its unpredictability accepted. Within days or weeks at most, people became sick and died usually at home; the most common causes were epidemics and pandemics, including influenza, pneumonia, diarrhea, smallpox, and tuberculosis (Olshansky & Ault, 1986). Children were particularly susceptible; among females, pregnancy and childbirth were major causes of death.

Following World War II, the United States experienced technological advances that radically changed medical practice and, as a result, attitudes toward dying and death (Callahan, 2005; Hardwig, 2009). Public health campaigns to improve sanitation, coupled with medical advancements, notably the introduction of antibiotic treatments, gradually shifted the causes of dying in America from infectious diseases to chronic degenerative diseases, primarily cancer, stroke, and cardiovascular disease (Olshansky & Ault, 1986). By the 1970s, epidemiologists observed that fewer people were dying from degenerative diseases. Life expectancy at birth had increased phenomenally from an average 47 years to 73.6 years (Olshansky & Ault, 1986). Biotechnology offered improvements in diagnosis as well as treatment, enabling physicians to postpone or delay death. The result was the beginning of "The Age of Delayed Degenerative Diseases."[2]

[2] S. Jay Olshansky and A. Brain Ault proposed "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases" in their 1986 paper of the same name. They built upon the "theory

Medical technology also lengthened the period of declining health that precedes death. Contemporary Americans are living longer but experience debilitating conditions (e.g., dementia) for a significantly longer time than previous generations (Hardwig, 2009). Improved medical treatment has transformed former terminal illnesses, notably many forms of cancer, into chronic illnesses.

Thus, the mortal, material body of history has been replaced in the 21st century by a conception of death as controllable, if not preventable. Dying has been discursively reconstructed as a medical problem more akin to a disease than a natural life event. The body is pathologized as a problem that can be and is expected to be resolved through medical intervention (Conrad, 2007; Lupton, 2003). As a result, discourse surrounding death has become "ambivalent" (Callahan, 2005; Dubler, 2005; Dugdale, 2010; Fins, 1999; Hardwig, 2009; Lynn, 2005; McCue, 1995; Whittington, 2011).[3] Americans expect a "new kind of death" (Hardwig, 2009, p. 38) in which the body is conspicuously absent. Findings from a *JAMA* study reported patients and families were most concerned with the psychological closure that a "good death" provides: "[l]ife review, saying good-bye, and resolving unfinished business"; "an opportunity for human development" (Steinhauser et al., 2000, p. 2481).

The ambiguous discourse that shapes contemporary public understandings of dying and death has permitted denial at the individual and collective levels. How an individual dies, when and where, have become matters of "personal prerogative" (Fins,

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of the epidemiologic transition" (p. 355) of disease patterns first identified in 1971 by A.R. Omran: The Age of Pestilence and Famine, The Age of Receding Pandemics, and The Age of Degenerative and Man-made Diseases.

[3]By "death," researchers mean adults in later stages of life, not young adults who die before reaching the age of their respective average life expectancy. John Hardwig (2009) clarifies this important distinction.

1999, p. 85). Americans believe they have the right to control their death, an attitude supported not only by medicine but the legal system as well. Legal mastery over death dates to 1967 when Luis Kutner, a Chicago civil rights lawyer, proposed the concept of a "living will" to give individuals the right to declare what medical care they would prefer at the end of life (*Encyclopedia of Death and Dying*). In the 1980s, "advance directives" were offered as improved legal documents intended to give healthy individuals the right to state which medical procedures they want in the future when they are dying. In 1976, California became the first state to allow legal directives that would terminate medical treatments. Fourteen years later, the U.S. Congress passed the Patient Self-Determination Act, giving all citizens legal access to advance directives. The result was, in the wry words of a visiting European health-care professional, "'Americans don't die, they just underachieve'" (Finn, 1999, p. 85).

At the societal level, denial of death is evident in the medical imperative. Also referred to as the "technological imperative" (Callahan, 2000, p. 654), the medical imperative is "the compulsive use of technology to maintain life" (p. 654); "to use every possible means to save life" (Callahan, 2005, p. SR6). Biotechnology research and improved medical procedures and treatments have made it possible, thus mandatory from a societal point of view, for physicians to prolong patients' lives. Illness no longer leads to death (Lupton, 2003, p. 93). Even for the elderly chronically ill, physicians are expected to aggressively order more tests, more procedures, and/or more interventions to sustain life, because "death is viewed as *not necessarily inevitable this time* " (Kaufman, 1999-2000, p. 81; emphasis in original). There is always "the possibility of an undiscovered disease" (McCue, 1995, p. 1039).

Discourse and the Body in Medicine

The medical gaze of the physician empowered the institution of medicine, laying the groundwork for medicalization. A social and rhetorical force, medicalization recasts problems related to the body in medical discourse, bringing them under medicine's social control. Over time, however, medicalization has had detrimental effects on the institution of medicine, notably on physicians, which impacts patient care particularly at the end of life.

Medicalization

The "medicalization thesis" (Lupton, 2003, p. 9) was introduced in 1970, bringing attention to the increasing jurisdiction of medicine. Although medicalization was instigated and continues to be supported by the institution of medicine, it is "an increasingly complex interplay of various social actors" (Conrad, 2007, p. 149), including patient advocacy groups, social movements, and corporations including the pharmaceutical industry, health insurance, and biotechnology.[4] Medicalization is defined as "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders" (Conrad, 2007, p. 4). Social problems that have become medicalized—behaviors traditionally regarded as deviant and abnormal—include alcoholism, mental disorders, sexual abuse, gender differences, and learning disabilities. Medicalization also extends to normal life processes and events, particularly those that are distasteful—when the body cannot always be brought under

[4] A related theory of "biomedicalization" (Clark et al., 2003) has been proposed by another group of researchers who examine medicalization through "a highly and increasingly technoscientific biomedicine" (p. 162).

medical control--such as in childbirth, menopause, aging, and dying.[5]

Death is "almost fully medicalized" (p. 6), redefined in medical discourse that physicians alone have legal and social responsibility to pronounce. When declaring a person dead, physicians use three definitions: clinical death, legal death, and brain death. Clinical death is "the term used to encompass that short interval after the heart has finally stopped, during which there is no circulation, no breathing, and no evidence of brain function" (Nuland, 1993, p. 121). Legal death requires "incontrovertible evidence that the brain has permanently ceased to function" (p. 123), which is not as easily recognizable to the physician as clinical death. When patients die on "life support," i.e., connected to machines providing mechanical or artificial respiration usually in trauma or intensive care units, the heart often continues beating after brain function ceases. Thus, physicians use specific criteria to determine brain death: "…loss of all reflexes, lack of response to vigorous external stimuli, and absence of electrical activity as shown by a flat electroencephalogram for a sufficient numbers of hours" (p. 123).

While these definitions prove the rhetoricality of death, they also disclose the troubling relationship physicians have with the nearly dying and newly dead bodies. They are required to legally declare the deaths of patients who die in American hospitals; they "call" the exact time of death. Yet, death is neither *a* moment in time nor *an* event but a process: "sequences of events by which tissues and organs gradually yield up their vital forces in the hours before and after the officially pronounced death" (Nuland, 1993,

[5] Even though sociologist Peter Conrad's overall concern is "with the widespread, perhaps overmedicalization, of human conditions, a trend that shows no signs of abatement" (2007, p. 146), he notes that medicalization has benefitted society as well. Individuals are no longer blamed for some conditions that have been medicalized, for example, alcoholism. Many people's lives also have been extended through the judicious use of medical interventions (p. 147). He does not consider these and other benefits to outweigh the detrimental effects of medicalization, however.

p. 42). Thus, even under medicalization, the dying body is unruly, and death as an event, a rhetorical construction. *Death*, like *life*, are "words [that] appear to be inventions of the human mind, perhaps shorthand notation for the 'processes of living' and the 'state of being dead,' respectively" (Bartalos, 2009, p. 272). Even for oncologists who regularly confront death in their medical practice, the meaning of dying is contested: "Each of us is dying now. Our teleomeres are shortening….So how is this different from a patient with incurable cancer who is 'really' dying?" (Wein, 2008, p.105).

Physicians' troubling relationship with the corpse actually dates back to the first week of medical school when they begin training in the gross anatomy lab. The cadaver "introduces" students to the human body, providing unique and invaluable insight into the living human body (Cantor, 2010). Yet, cadavers also inure trainees to depersonalized relationships with bodies. Students learn to touch and view bodies in ways that objectify them into medical specimens. They learn to "overcome any emotional barrier" to the dead body by focusing on the "biovalue" (Fountain, 2014, p. 169) or usefulness of the body. Thus, the cadaver is objectified into an anatomical specimen and the body, "an instantiation of anatomy" (p. 121). Working on cadavers, trainees learn "to see, feel, and think the way a physician does" (p. 9): a "trained vision" that is a "perceptual, intellectual, and rhetorical framework by which participants make sense of anatomy" and which "mark[s] them as members of this medical community" (p. 46). Cadavers, then, are used to transform trainees into physicians who are different kinds of people; an example of institutional control that is carried out through the "hidden curriculum."

The Hidden Curriculum

The institution of medicine controls the practice of medicine through two curricula that comprise medical education. One is the formal curriculum articulated in lectures and didactic sessions. The other is an informal or "hidden curriculum" (Hafferty & Franks, 1994), tacitly taught through discourse not officially sanctioned but recognized as essential medical knowledge. The hidden curriculum was revealed by behavioral scientist Frederic W. Hafferty and Ronald Franks, a physician and former medical school dean, in what has been called one of the most far-reaching, impactful articles on medical education and training since the 1920 Flexner Report (Doukas, McCullough, & Wear, 2010; Martin, 2013; Riggs, 2010).[6] However, the hidden curriculum remains a powerful force in medical training. One of the goals of this study has been to interrogate how physicians-in-training, in collaboration with editors of medical journals, are subverting the hidden curriculum through the creation and publication of oppositional medical discourse.

A major claim of Hafferty and Franks was that medicine is not a value-free discipline nor is medical education the transfer of objective, scientific knowledge. Medical education is a process of socialization that transforms students as persons into physicians who are different from, thus set apart from, other types of people. An essential part of this enculturation is learning the professional community's moral values and behavioral norms, which are imparted through the hidden curriculum: "informal processes such as 'general clinical experience,' peer interactions, 'ward rounds,' and 'role

[6] In 1910, Abraham Flexner was asked by the Carnegie Foundation to assess the varying quality of medical education in the United States as the first step in instigating major reform. Flexner strongly recommended more scientific training and rigor, and a rational approach to medicine. The 4-year medical school is the result (Riggs, 2010).

models' rather than formal coursework" (Hafferty & Franks, 1994, p. 862). Physicians-in-training learn to distance themselves affectively from patients they "care" for by objectifying the people into diseases that can place frustrating demands upon their already limited time. They learn to value technical and scientific expertise necessary to carry out the medical imperative and to fear patients' death, which represents their failure personally and professionally. Above all, they learn "*medical morality* and [its] supporting rationales" (p. 865; emphasis in original). Trainees learn what is appropriate to say and not say; how to act and not act. Thus, medical morality disciplines the bodies of novitiate physicians through discourse.

Disempowered Physicians

Medicalization empowers the institution of medicine and the hidden curriculum likewise empowers the institution. A consequence, however, is the disempowered physician, which becomes problematic when personal loss causes professional lapses. The hidden curriculum has caused documented moral distress in physician-trainees. Medicalization has exacerbated the consequences of the hidden curriculum in terms of the hospital environment; the medicalization of time and the dehumanization of patients and physicians.

Physicians-in-training learn through the hidden curriculum to change their perception as human beings; "to transform that which is startling, disquieting, and/or morally unsettling into something that is routine, acceptable, or perhaps even to be preferred" (Hafferty & Franks, 1994, p. 864). However, trainees inevitably encounter clinical situations where they cannot reconcile the conflicts between what they have been

formally taught, informally witnessed, and personally believe. The result can be "insidious" (p. 866), ranging from cynicism (Branch et al., 2001) to moral distress (Christakis, 1996; Lomis, Carpenter, & Miller, 2009; Rhodes-Kropf et al., 2005), which is defined as "negative feelings that arise when one knows the morally correct thing to do but cannot act because of constraints or hierarchies" (Wiggleton et al., 2010, p. 111). The professional repercussions of personal moral distress are disengagement from patients, professional burnout, and poor clinical judgment (Meier, Back, & Morrison, 2001).

The hospital environment exacerbates the situation; it is the embodiment of the medical imperative, which disempowers individual physicians even as it empowers the profession. The mandate constrains physicians' medical practices; it "narrows doctors' field of possibilities and thus removes options" by "forcing physicians to equate good, appropriate care with maximum intervention" (Kaufman, 2005, p. 41). Their ability to make decisions regarding the care of patients is further constrained by the hospital bureaucracy. Physicians must take into consideration reimbursement structures, relationships with other physicians inside and outside their specialties, staff hierarchies, and their own income (Lupton, 2003). Thus, physicians are pushed personally onto "the heroic pathway" to prolong every life, a path that is in reality "determined by the bureaucracy" (Kaufman, 2005, p. 131).

Medicalization also has intensified the compression of time, which takes control away from physicians. Postgraduate training is constrained by "'tight schedules' and 'limited time'" (Hafferty & Franks, 1994, p. 867). Resident work hours were reduced in recent years (see Chapters 4 and 5; Gaufberg, 2008) to help reduce stress and burn-out. An unintended consequence, however, is less time for interns and residents to develop

meaningful relationships with patients (Stern & Papadakis, 2006). Trainees learn to treat patients with "professional detachment," rather than "personal interaction" (Lupton 2003, p. 128). Not incidentally, detachment also frees them to respond to "the omnipresent 'beeper'" (p. 102), the real determinant of their clinical schedule. In the interest of time—which, for hospitals dealing with managed care contracts, translates into economics--residents learn to discharge patients as soon as possible to keep hospitals operating "as rapidly and cost-efficiently as possible" (Kaufman, 2005, pp. 96-97).

Depersonalization that disempowerment causes is also evident in the ways patients are "cared" for in hospital. Patients lose their status as persons; they lose authority of their lives and are alienated from their bodies. This sense of dehumanization can be further aggravated when physicians-in-training, themselves experiencing depersonalization through the process of medical socialization, react with emotional detachment, resulting in moral distress on both sides of the doctor-patient relationship. This situation was described and documented in the landmark 1995 SUPPORT study (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments). Improved clinical medicine has extended lives, but patients still experience[d] "prolonged dying, accompanied by substantial emotional and financial expense" (*JAMA* 1995, p. 1591).

Challenges to Discourses of Medicine

Aside from Foucault, several other lines of scholarship inform my work. While Foucault allows for an understanding of the institutionalization of medicine, other theorists incorporate the body into the experience of medicine, whether implied or tacitly.

To investigate how physicians-in-training subversively wield discourse in response to medicalization and the hidden curriculum, I draw upon the material rhetoric theories of Michael McGee and Debra Hawhee who articulate relationships between discourse and bodies. I also use theories of narrative proposed in health communication and medicine to contextualize the oppositional narrative discourse of physicians' and to understand how the discourse challenges the power and control of the institution of medicine over the personal and professional bodies of physicians. Combined, this scholarship helps resituate the medicalization of death and dying.

Material Rhetoric

Michael McGee was among the first contemporary rhetoricians to argue for the materiality of rhetoric. Viewing rhetoric as "a form of relationships and not a set of facts"; "a medium, a bridge among human beings, the social equivalent of a verb in a sentence" (1982, p. 27). McGee claims rhetoric is "'material' by measure of human *experiencing* of it." This conception, developed for public speaking, focuses on "the specific *relationships* which 'speaker/speech/audience/occasion/change' bear to one another in actual human experience" (p. 29; emphasis in original). Although the speaker's body is not specifically referenced, it is implicitly incorporated into the human experience.

Particularly relevant to my research is Debra Hawhee's approach to material rhetoric, which disrupts the traditional history of rhetoric with the re-envisioning of rhetoric as a bodily art. Hawhee's scholarship recuperates a long forgotten practice of rhetoric: how ancient Greek rhetoricians were trained to perform *physically* as well as

mentally. In ancient Greece, education had been based on Isocrates' "compounded self" or "body-mind" (p. 5, a notion that "did not draw together two parts previously separated" (p. 5) but considered them as one. Individuals were required to train simultaneously in discourse and gymnastics, so they would learn "moves in response to a situation rather than through the application of abstract principles" (p. 10). This dual training would lead to the successful embodiment and performance of important Greek values, notably *arête* (virtuosity) and *metis* (cunning intelligence)**.** The body was as critical as the mind to rhetorical performance. Hawhee's work recovers the body, repositioning rhetoric as a material practice as opposed to a cerebral practice, which had become the dominant conception of rhetoric.

Emphasis on the performance of the body-mind adds critical dimension to the practice of rhetoric; it relates the body to discourse, which empowers the individual rhetor. Arguments can be literally fleshed out, giving new meaning to rhetorical appeals of *ethos*, *logos,* and *pathos*, and, in the context of this study, *kairos*. Usually interpreted as the "right" or opportune time that a rhetor can use to his advantage in persuading audiences, *kairos* has other nuanced definitions relevant to the body. Homer used the adjective form of *kairos* "to indicate a critical, fatal spot on the body, e.g., 'where the collarbone parts the neck and chest'" (Hawhee, 2004, p. 66) that ancient archers would aim for. *Kairos* also is an important term in weaving, where different forms of the word mean: "the place where threads attach to the loom"; "the act of fastening these threads"; "a web so fastened"; and "a woman who weaves" (p. 67). With this multidimensional understanding of *kairos,* Hawhee builds upon McGee's theory of material rhetoric and argues for the explicit and necessary incorporation of the body, which, in this study,

directly bears upon medicine.

Like rhetoric, medicine is contingent upon the body; it is an embodied practice. However, contemporary medicine, as I argue in this study, has distanced both the corporeal, affective body of the physician and the personal, natural body of the patient. Material rhetoric, particular the embodied rhetoric Hawhee presents, affords theoretical backing for my argument. Ancient Greek physicians performed "bodily *kairos*—momentary, embodied perception of somatic symptoms—to make the right diagnosis at the right time" (p. 70). Physicians used their bodies to diagnose and treat the bodies of patients; *kairos* afforded physicians agency. But *kairos* can also be interpreted in a reverse sense in which "the rhetor opens him or herself up to the immediate situation, allowing for more of an exchange" (p. 71); rhetorical agency is reversed and the *kairotic* body acts upon the rhetor. Hawhee refers to this type of opening as "kairotic inspiration" (p. 71). I draw upon this model n my rhetorical analysis of the agency of nearly and newly dead bodies.

Narrative

Narrative is the form and content of physicians' discourse, a subversive choice in the culture of medicine. It explicitly opposes the disciplinary discourse of the institution of medicine, which controls members of the profession through rhetorical limitations. The institution traditionally has disallowed use of grammatical first-person and active voice. Physician-authors flaunt these rules with their use of personal narrative. They take authority and use it to reconstruct their personal identity through reflection, a rhetorical stance that is professionally discouraged. However, narrative does have sanctioned roles in the institution of medicine. I begin by reviewing how narrative is used to structure and

convey medical knowledge, and to improve physicians' clinical skills. I follow with a review of how patients use narrative to re-personalize their bodies and selves, an emphasis in rhetorical scholarship in health communication. I then review narrative discourse analysis and select literary theories of narrative that I draw upon in this study to understand physicians' personal narratives.

Sanctioned Uses of Narrative in the Institution of Medicine

Structuring and Conveying Medical Knowledge

Narrative is used routinely in medical practice and education to control (Montgomery Hunter, 1991). Case histories of patients are used to interpret general, abstract scientific information and apply it to the treatment of individual patients. Patient histories and case histories are used to educate trainees and also to advance medical knowledge. Underlying these functions of narrative, however, is the radical notion that medicine is not the science many presume it is (Greenhalgh, 1998). Medicine draws from objective, scientific knowledge, but it is fundamentally an "interpretative activity" (Montgomery Hunter, 1991, p. 1). Physicians are "authors of the text-that-is-the-patient" (p. 12), "reading" the body of the patient as well as listening to the patient's narrative of illness. This clinical knowledge is "necessarily filtered through the consciousness" of the physician, rendering it "contextual, embodied, and potentially uncertain" (p. xxii). Once this subjective information is recorded in the patient's medical record, it is objectified; the "ultimately unknowable person" is transformed "into a knowable, narratable, and thus treatable medical entity" (p. 12). Thus, the institution manages to retain control even of narrative.

In evidence-based medicine, narrative also plays a key role in "the professional mastery of practical procedures" (Greenhalgh, 1998, p. 257). Physicians draw upon four types of "texts" or narratives during patient counters: "the *experiential*" (p. 257), the meaning the patient ascribes to his or her experience of suffering, which s/he may or may not tell the physician; "the *narrative*" (p. 258), the medical problem the physician identifies from the narrative the patient does tell; "the *physical* or perceptual," the narrative of disease "told" by the body during the physician's examination of the patient; and "the *instrumental* ," which refers to narratives of disease revealed by diagnostic tests, e.g., X-rays. When used together, these narratives constitute "the 'art' of clinical judgment" (p. 261) that evidence-based medicine as an integrated practice "requires" (p. 263).

Improving Physicians' Clinical Skills

Physicians also use narrative as a clinical tool (Brody, 1987/2003; Charon, 2006; Greenhalgh & Hurwitz, 1998; Kleinman, 1988) to improve their relationships with and care of patients by listening for and to patients' narratives so they can more effectively care for patients with understanding and empathy. Listening to patients' narratives is "a core task in the work of doctoring" (Kleinman, 1988, p. xiii), albeit one that has "atrophied in biomedical training" (p. xiv). Listening empowers physicians who can understand how patients make meaning of their illness and thereby provide more appropriate treatment and care.

How physicians learn to listen to patients is addressed in "narrative medicine," a theory developed and described in depth by physician and literary scholar Rita Charon.

She advocates that physicians demonstrate narrative competence, defined as the ability "to recognize, absorb, interpret, and be moved by the stories of illness" (2006, p. vii). She intends *Narrative Medicine: Honoring the Stories of Illness* as "a manual…to teach such narrative skills as close reading, reflective writing, and bearing witness" (p. x). Physicians are cued to listen for "metaphors, images, allusions to other stories, genre, mood—the kinds of things that literary critics recognize" (p. 66).

Narrative as Articulation of Patients' Experiences

Narrative enables persons who have been redefined by the institution of medicine as "patients," identified in biomedical terms related to their diseases, to regain control of their lives by recounting their personal experiences with illness (Brody, 1987; Frank, 1995; Harter, Japp, & Beck, 2005; Hawkins, 1999; Mattingly & Garro, 2000; Scharf & Vanderford, 2003). Patients repair or reconstruct their identities in ways that incorporate their damaged identities and bodies (Frank, 1995; Nelson, 2001).

The critical importance of illness narratives is in "restoring the patient's voice to the medical enterprise" (Hawkins, 1999, p. xii). Patients use narrative or storytelling to make sense of their illnesses, to assert control in the midst of physical and psychological loses, and to transform their identities and social roles that have been changed by disease (Scharf & Vanderford, 2003). Narrative helps patients manage the tension between the external physicality of disease and the internal symbolic representation of illness, for in narrative, "materiality and meaning are comingled" (p. 13). When patients tell their stories, they gain control over their lives that disease and medicine has taken away: "narrative form puts the 'I' back into a person's understanding of his or her life" (p. 21)

by reordering life events to give them new meaning. Thus, patients transform their identities through the "identification of critical, life-changing incidents…and the integration of personal expertise and adaptation to illness" (p. 22). Their narratives function as testimonies that physical "crises may be overcome, survived, and understood"; that "profoundly destructive experience" can be "transform[ed]…in ways that heal" (Hawkins, 1998, p. xix) beyond what medicine offers.

Illness narratives have been called "our modern adventure story" (Hawkins, 1998, p.1) with disease cast as "risk and danger" that send individuals into "the deeper realities of life." Anne Hunsaker Hawkins argues that these texts constitute a new genre of literature she calls *pathography*: "a form of autobiography or biography that describes personal experiences of illness, treatment, and sometimes death" (p. 1). Particularly relevant to this dissertation is her definition of pathography as "a subgenre of autobiography, especially in the way I use literary theory" (p. 3); Hawkins squarely situates illness narratives within the hierarchy of literary studies and outside medical discourse. Her primary critical interest is the function of pathography as "a rich source for the literary critic" (p. 3), especially as illustrations of myths of rebirth and cure, battle and journey, dying, and medicine. She maintains that pathographies represent mythical thinking as well as mythical functions, including "*re*-formulation" (p. 24) of illness experiences as reparative: a prevalent theme in narrative and medicine.

Narratives of patients who experience "disrupted personal lives, threatened relationships, and spoiled identities" need "readjustment and repair" (Harter, Japp, & Beck, 2005, p. 2). Narrative repair is central to the work of medical sociologist Arthur W. Frank. "Becoming seriously ill is a call for stories" (1995, p. 53); "[s]tories have to

repair the damage that illness has done to the ill person's sense of where she is in life, and where she may be going" (emphasis in original). Disease has a universal impact on life stories: "The illness story is wrecked because its present is not what the past was supposed to lead up to, and the future is scarcely thinkable" (p. 55). Narratives function as repair when patients begin telling "'self-stories,'" a term borrowed from psychoanalyst Roy Schafer[7] that denotes how "the self is *formed* in what is told" (p. 55; emphasis in original) to others as well as to oneself. Thus, the patient "finds her voice" through telling her story: an essential aspect of identity that, like the temporal arc of her life, has been disrupted by disease.

Philosopher Hilde Lindemann Nelson introduces her theory of narrative repair (2001) with personal narratives of nurses, although she intends for her work to apply more broadly. Narrative is reparative when individuals create "counterstories" (p. 8): "stories that define people morally, and are developed for the express purpose of resisting and undermining an oppressive master narrative." Counterstories can be about either individuals or groups of individuals whose identities are damaged through two types of oppression: when institutions identify individuals as "morally sub- or abnormal" (p. 20) or when a person "internalizes as a self-understanding the hateful or dismissive" view of others (p. 21). Through narrative repair, an individual can "attain, regain, or extend her freedom of moral agency" (p. 150).

[7] Roy Shafer's article, "Narration in the Psychoanalytic Dialogue," is included in W.J.T. Mitchell's well-known edited collection *On Narrative* (1980), compiled from presentations at one of the first symposia on the social and psychological roles of narrative across numerous disciplines.

Theoretical Concepts of Narrative in Health Communication

Narrative Paradigm

The narrative paradigm does not specifically reference health or medicine, but it is relevant to this dissertation, since the model serves as the foundation for scholarship in health communication and narrative. Walter Fisher proposed the "narrative paradigm" as an alternative to the "rational world paradigm" (Fisher, 1984, p. 3), the traditional rhetorical model of how humans communicate contingent on a knowledge base that has to be learned. He claimed that narrative is the primary and fundamental way that all individuals encounter and behave in the social world; people are *homo narrans* or "storytelling animals" (p. 1). People use narrative to order their individual experiences and give them meaning, as well as to create community by connecting to others through stories. Thus, narrative has the potential to bridge dualisms that have always problematized communication, including intellect/imagination, reason/ emotion, and fact/value.

Narrative Inquiry

Narrative inquiry was developed in response to examination of patient narratives and continues to evolve theoretically. Initially, scholars combined the narrative paradigm with social constructionism to understand how patients' storytelling could resolve the tension between the "material reality of illness" or biomedical experience of disease, and the "symbolic representation" (Sharf & Vanderford, 2003, p. 10) of illness, the meaning of their illness experience in terms of their life and person.[8] Narrative bridges the divide

[8] This is essentially what Eliot Mishler (1984) described as the "voice of medicine" and the "voice of the lifeworld."

by enabling individuals to: make sense of health and disease; assert control over their "diseased" identity and redefine their social roles; "warrant" moral decisions regarding their past behaviors, beliefs, and values; and build community by uniting individuals with similar conditions and raising public awareness about health issues.

In recent years, narrative inquiry has shifted focus to the social construction of health, as opposed to the individual expression of illness. Likewise, the function of narrative has been revised; narratives serve as mythic representations that reconstruct social reality. Narrative has been redefined as "socially constructed stories" that "make sense of uncertainty" and "further construct social reality" (Sharf, Harter, Yamasaki, & Haidet, 2011, p. 38). Illness prompts the narrative, but the telling is a "quest for deeper meanings," "an enactment of resilience" (p. 37). Health narratives are "implicit explanations" (p. 38) of causality, remedies, and possibilities, which bring about improved health. In place of the conflict between the material reality of illness and the physical experiences of patients are "tensions" between "knowing and being," "continuity and disruption," "creativity and constraint," and "partial and indeterminate" (p. 38).

Narrative as Discursive Opposition to the Power of Medicine

To interrogate how physician-authors use the discourse of personal narrative to challenge the institution of medicine, I draw upon rhetorical and literary theories of narrative. Narrative discourse analysis, a rhetorical approach, reveals the relationship between social power and discourse. The three literary theories of narrative I review proved useful in understanding how physician-authors use narrative discourse to deal

with conflicts between competing tensions and voices in the institution of medicine; different conceptions of reality they encounter in their medical practices; and forces, especially the progression of time, that shape their personal identities.

Narrative Discourse Analysis

Narrative discourse analysis, also referred to as narrative analysis, is not commonly used in health communication or medicine, but it provides a way to understand the structure of narratives at multiple levels—words, clauses, texts—and allows for an examination of how power is discursively produced by individuals, groups, and culture.

Narrative analysis has its theoretical foundation in linguistics. William Labov and Joshua Waletzky (1967) collected and analyzed oral narratives, "personal experience narratives," from which they identified a "deep structure": a morphology similar to Vladimir Propp's (1928/1968) analysis of the deep structure of Russian folktales.[9] The basic element is the clause, which is joined to other clauses in temporal order, affording analysis of narratives at the levels of word and text. These levels of narrative were revised (Johnstone, 2001) into five stages or functions of narrative: *orientation,* a group of clauses that introduce the situation; *complication*, clauses that recount a sequence of events that lead to a climax; *evaluation* in which the narrator states what is interesting or unusual, thereby encouraging the audience to keep reading or listening; *result* or *resolution*, the final events that resolve the narrative's tension or suspense; and *coda,* a

[9] The beginning of scholarly work in narrative is traced to Vladimir Propp who proposed in the 1920s to make a science of literary analysis by identifying the deep structure found in all literature, which could be used for an objective analysis, in contrast to the more subjective analysis of thematic content.

summary or a suggestion as to how the narrative of the past relates to the present.

The morphology highlights two critical purposes of narrative: It "circulates social power" and "creates and perpetuates social relations" (Johnstone, 2001, p. 644). Narrative analysis is concerned with "the political effects of narrative" (p. 644); narrative can be used for negotiation as well as domination. Like critical rhetoric, narrative analysis' methodology helps to "unmask" discourses of power and "demystify" how these dominate particularly when used to create and maintain institutions (Linde, 2001). Narratives can function as "oppositional stories" that temporarily reverse the social order; "countermemories" or "counterhistories" that criticize official narratives; and "erasures," narratives that institutions delete from their history when the events conflict with officially condoned accounts (p. 529).

Selections from Formal Literary Theories of Narratives

Dialogism: Conflict and Meaning

Understanding narrative as the co-construction of competing languages is a significant contribution to narrative theory from literary theorist Mikhail Bakhtin.[10] In terms of health communication and medicine, Bakhtin's theory helps to explain how narrative creates meaning within the conflict between voices whether they are patients', physicians', or that of the institution of medicine. His work is cited by many theorists referenced in this study (Berkenkotter & Huckin, 1995; Harter, Japp, & Beck, 2005;

[10] Bakhtin is identified here as a literary theorist because of the context. Critics have perhaps more accurately called him "one of the leading thinkers of the twentieth century" (Clark & Holquist, 1984, p. vii). His theories can be difficult to categorize, since Bakhtin resisted formalization, but they are all concerned with the concept of language. Since he discussed the grotesque body in terms of the novels of Rabelais, it could be mentioned here in relation to literary theory. However, Bakhtin does not discuss the relationship of the body to narrative in theoretical terms of narrative.

Johnstone, 2007; Ochs 1997).

Dialogism is perhaps best understood as the creative synthesis of dialogue and dialectic. We communicate through utterances, "contradiction-ridden, tension-filled unity of two embattled tendencies in the language" (1981, p. 272). The contradictory forces are "centripetal," or movement toward a center so as to unify, and "centrifugal," or movement away toward decentralization (p. 272). When language moves away from itself, it joins with other social and historical languages, leading to "heteroglossia" (p. 273). Though the term translates into "many-tongued-ness," it is understood generally as the recognition of different and multiple languages within language. Every character in a novel, for example, has its own voice as does the narrator; the historical, social and cultural settings also have characteristic "voices" or languages. The multiplicity of these often conflicting voices comes together in their difference. Heteroglossia applies to narratives that are not strictly literary, for all narrative is in a sense co-constructed by competing languages. Within the liminal space of conflict, new meaning can be created.

Psychological Theory of Narrative

The psychological theory of narrative of Jerome Bruner (1986, 1991) contributes to a deeper understanding of how narratives are co-constructed and provides a conception of "reality" that relates the institutionalized "real" world of biomedicine and disease, and the "actual" world experienced by patients and their families. Physicians-in-training straddle these worlds as persons not yet fully enculturated into the profession of medicine—the real world of medicine--which permits them to simultaneously live as lay persons in the actual world.

Bruner distinguishes between two ways of ordering experience and constructing reality. The "paradigmatic or logio-scientific" (1986, p. 12) mode aims for universal truths reached through formal logic. It is an empirical, argument-based, and non-contradictory mode. In contrast, the "imaginative" or "narrative" (p. 13) mode aims for verisimilitude, established through stories or narrative, which "deals with the vicissitudes of human intentions" (p. 16). People have intentions which they act upon; drama is created when there is an imbalance between intentions and actions. Narratives about these dramas construct two "landscapes" or worlds: one is the "land of action" with agents having intentions, acting upon goals, involved in situations; the other is the "land of consciousness," the "psychic reality" (p. 14) of the agents' thoughts, feelings, and knowledge. Narrative is dominated by psychic reality. "Stories are about events in the 'real' world, but render that world newly strange" (p. 24). Bruner's theory provides a framework for investigating differing and conflicting perceptions of reality, each of which is equally valid: a theory relevant to the analysis of personal experience narratives.

Narrative, Time, and Identity

One of the only theorists to relate narrative, time, and identity is Paul Ricoeur (1980, 1984, 1991). His understanding of narrative, influenced by a phenomenology of time (Heidegger, 1962), contributes to an in-depth critical analysis of narrative as the reconstruction of self-identity in time. Particularly relevant to this dissertation is his notion of the "deep unity" (1980, p. 176) of time as past, present, and future, which directly opposes time defined by the institution of medicine.

Narrative and time have a "reciprocal relationship" (1980, p. 165): time is structured through language, while narrativity is essentially about temporal relations. Plot, "the crossing point of temporality and narrativity" (p. 167), provides a means for Ricoeur to propose three levels of time. At the most basic level, time is conceived of successive moments; our common perception of plot. Characters are "preoccupied" (p. 168) with time as they look back at events in order to emplot them into a coherent whole. This level is "within-time-ness" (p. 168), a term adapted from Heidegger. At the next level of "historicality and repetition" (p. 176), time is understood as the "extension" between birth and death, which is characterized by change as well as coherence. Change is possible through repetition: Characters reflect on past events in order to anticipate the future, thereby "repeating" the past. But during repetition, they are also "going back to possibilities that have-been-there" (p. 178). The result is that time as "extension" unites past, present, and future in a way that defies our common understanding of plot. At the third level of time, "the deep unity of time," Ricoeur adds the notion of "narrative repetition" (p. 179). Characters do not simply plot action "in time," as they do in historical time, but in their memory. Through memory, they recollect events, described as a "spiral movement that brings back potentialities that narrative retrieves" (p. 182). Thus, action "is recollected in stories whose function it is to provide an identity to the doer, an identity that is merely a narrative identity" (p. 183). The deep unity of time, then, affords a reconstruction of self-identity as a recollection of a potential self realized through memory.

In later works (1991), Ricoeur expands the concept of narrative identity to include readers. Not only do humans need narrative to make sense of their lives, but narratives

likewise need readers. Like Bruner, Ricoeur believes that narratives are never completed in the text; they are completed through the act of reading in which readers "live" in the world of the story through their imagination. Readers also are living in their experiences, however. To make meaning of their lives, they learn universal truths from stories, which they then apply to their lives. Thus, identity or subjectivity is found in the "interplay" of the world as text and the world of the reader's experience. This understanding of narrative is useful for interrogating the publication of physicians' personal narratives in medical journals and the impact of physicians' oppositional discourse on their disciplinary colleagues.

CHAPTER 3

METHODS

Introduction

The corpus of this study consists of personal texts that physicians have written about their experiences with dying patients and dead bodies during their training years. While all authors in the study corpus are physicians, the temporal setting of their accounts is limited to experiences from their years of postgraduate medical training. I chose to focus on this period of physicians' careers, because physician-trainees are "an important barometer" (Hafferty & Franks, 1994, p. 868) of the culture of medicine. They are not inured to medicine's "taken-for-granted 'realities'" (p. 868); they have not yet accepted troubling aspects of medical practice and will likely voice their affective responses. In contrast to practicing physicians who have been fully enculturated into medicine, adopting a medical identity and institutional perspective, trainees are more likely to provide accounts of dying and death that are like those of lay persons. I refer to authors who are physicians-in-training as "residents," "physician-trainees," and "trainees"; when authors refer to themselves as "interns" or "fellows," I use those terms.

Personal texts authored by physicians who write about remarkable experiences from their residency training with nearly and newly dead patients, and which are published in general medical journals, are a rich resource of knowledge about the practice

of medicine at the end of life for several reasons. First, physician-trainees provide an especially valuable perspective when examining taken-for-granted information regarding patient care. Accounts that focus on medical care of nearly and newly dead patients also call into question how practitioners attend to patients as well as to bodies that are no longer living. Finally, publication of these texts in professional medical journals allows inquiry into the paradoxical juxtaposition of subjective writing that incorporates personal narratives and objective, scientific accounts of original research.

Data

Corpus

I have selected texts that focus on trainees' experiences with patients who are nearly and newly dead, since these encounters are among the most challenging topics in medical education, medical ethics, and professional practice (Jewell, 1999; Schultz, 2003; Wolf, Asch, & Payne 2013). Trainees' responses are affectively unfiltered and raw, as previously noted. Equally important for this project, trainees' texts about dying and dead patients highlight the rhetorical impact that medical discourse has at one of the most problematic stages of life: in other words, how to refer to the body of a dying or dead patient.

Medical education has been criticized for not adequately preparing medical students and trainees to deal with death. End-of-life patient care still ranks "at the top of bioethical issues" (Wolf, Asch, & Payne, 2013), according to ethicists at a 2014 national meeting of the American Society for Bioethics and Humanities. There are more publications about the end-of-life than any other biomedical topic, yet less resolution and

few if any agreed upon guidelines for medical practitioners. One reason cited is that physicians' conflicted relationship with death has only become increasingly "difficult, medically and psychologically" (Callahan, 2000, p. 655). Even for oncologists who can expect to routinely experience patients' deaths in their medical specialty, "powerful emotional experiences [are reported] as a result of patient loss" (Granek, Krzyzanowska, Tozer, & Mazzotta, 2012, p. 1254), experiences that are considered "unprofessional and a personal and professional failure." Compounding this cultural stigma is the medical discourse surrounding death, which perpetuates its denial. According to Judy Segal, physicians are schooled in "[a] biomedical rhetoric of death" that defines death as "medical failure." (2000, p. 13).

Publication in Medical Journals

I have selected as my study corpus texts that physician-authors publish in medical journals, because they represent significant contributions to the profession and the practice of medicine, which also impact medical education and training. These texts bring into view a rhetorical situation in the medical discourse community that has yet to be examined in scholarly literature: the inclusion of subjective discourse in medical journals and the tacit acknowledgement of the value of personal writing to the professional practice of medicine.

The corpus consists of articles published in 14 medical journals that focus on primary care. These are among the most widely read journals as their contents are applicable across medical specialties. The journals solicit physicians' personal writing, described variously as "personal vignettes" (*JAMA*); "reflections" (*Journal of General*

Internal Medicine); "personal essays" (*Annals of Emergency Medicine*); "personal stories" (*Health Affairs*); "brief accessible pieces" (*New England Journal of Medicine*); and "brilliant missives" (*Canadian Medical Association Journal*). The articles, though described in various ways, share common goals: "the discussion of important societal issues that affect our lives as physicians, medical scientists and citizens" (*American Journal of Medicine*); "nonscientific and not strictly clinical observations, experiences, reflections" (*JAMA*); and the "humanistic aspects of patient care" (*Journal of General Internal Medicine*); all of which "speak of our practice in a very real and personal way…[that] reflects the creativity and drama of our specialty and our humanity" (*Annals of Emergency Medicine*). The titles of the sections in which the articles appear also speak to the purpose of including personal writing: "Perspective" and "Becoming a Physician" (*New England Journal of Medicine*); "A Piece of My Mind" (*JAMA*); "On Being a Doctor" (*Annals of Internal Medicine*); "Change of Shift" (*Annals of Emergency Medicine*); and "Narrative Matters" (*Health Affairs*).[11]

Physicians' manuscripts undergo peer review either by outside reviewers or a single editor who accepts or rejects the articles. Though increasing in journal presence over the years, personal writing is placed at the bottom of the hierarchy of writing published in medical journals. The *AMA Manual of Style: A Guide for Authors and Editors* (Iverson, 2007) lists eight types of writing in order of importance: reports of original data; review articles; descriptive articles; consensus statements and clinical practice guidelines; articles of opinion; correspondence; reviews of books, journals, and other media; and other types of articles. The last category is described as "other items

[11] In Chapter 4, The Matter of the Corpus, I discuss in detail reasons why and when medical journals expanded to include separate sections for physicians' personal writing.

and articles that do not fit into any of the major categories. Examples include personal reflections and essays (e.g., A Piece of My Mind in *JAMA*)" (p. 5). Thus, physicians' personal writing published in medical journals offers rich data with which to explore the relationship between personal medical discourse and the professional practice of medicine. More specifically, it affords a dual investigation of the tacit acknowledgement of practical and necessary medical knowledge that physicians offer in their personal texts and the challenges to end-of-life medical care covered in the hidden curriculum and voiced by physician-trainees in their personal texts.

Procedures

Data Collection

To find physicians' personal writing about encounters with dying patients from their clinical training, I conducted a PubMed Medline search of medical journals using a broad range of terms:

> ("terminal care" OR "end of life" OR end-of-life OR death OR dying OR mortality OR corpse) AND (student OR students OR residency OR resident OR intern OR internship) AND (personal narrative OR autobiography OR autobiographical OR editorial OR diary OR essay OR essays OR anecdote OR anecdotes OR anecdotal OR interview OR interviews). [12]

The result was 1,087 interviews/narratives/articles on death/dying and internship/residents/trainees. These articles were filtered three times. First, the terms "[t]erminal care" or "end of life" narrowed the results to 509 articles; the additional filter

[12] Assisting me in this search was Mary McFarland, M.L.S., information and technology consultant at the University of Utah Spencer S. Eccles Health Sciences Library, whose expertise and guidance helped ensure that my searches were thorough.

"core clinical journals" resulted in 78 articles,[13] which were further filtered using key terms "personal narratives/autobiography." The final result was 14 articles. I closely read those and identified five that met the three-pronged criterion I had established[14]: each was written by a physician about an encounter with a dying patient or corpse that was experienced during her/his postgraduate medical training; each was published in a general medical journal; and each was written in its entirety as, or included at least one, narrative recounting a personal experience as described above.

Since the first five narratives texts were published in four different journals--*American Journal of Medicine, Annals of Internal Medicine, Canadian Family Physician,* and *Journal of the American Medical Association (JAMA)*—I initially focused on these publications. I conducted both PubMed and EBSCO searches within each journal using the MESH terms "death," "dying," "internship and residency." During my research, I noticed many of the narratives appeared repeatedly in particular sections of the magazines, for instance, in "A Piece of My Mind" in *JAMA* and "On Being a Doctor" in *Annals of Internal Medicine.* I then conducted searches for those sections, again using PubMed and EBSCO, and read through each narrative, identifying those that met all of my criteria.

Additionally, at each of the above stages, I employed "snowballing" or the "snowball sampling" technique. Frequently used to recruit subjects for participation in a research study, snowballing is defined as the solicitation of names of potential subjects

[13] I limited my search to "core clinical journals" after consulting with several physicians and McFarland. They advised me that general medical journals are read more widely than those published by medical specialty organizations.

[14] Abstracts are included in about 40% of these types of articles. Thus, I did a cursory reading of each article, followed by a close reading before making selections.

from subjects already enrolled in the study (Streeton, Cooke, & Campbell, 2004). I adapted the technique by reading all "Related Citations in Pub Med," as well as articles related to those that were identified by the search engine; in other words, references "referred" me to personal texts on similar topics. This research technique significantly broadened the number of medical journals I searched. I continued the process until I reached a saturation point where the titles of particular narratives began reappearing in my searches.

Using these techniques, I collected a total of 138 articles published in 18 medical journals.[15] Although I had specified "core clinical journals," my search turned up articles in five journals seemingly outside the range of general medical journals that focus on primary care. The *Journal of Clinical Oncology* and *Journal of Palliative Medicine* were two examples. I decided to delete the eight narratives found in *Journal of Clinical Oncology*, because trainees choosing to pursue oncology could expect to regularly encounter dying patients; their experiences with death would not pose the exigence they might in the practice of primary care medicine.[16] In contrast, I have included writing from the *Journal of Palliative Medicine*, since the physician-authors identified themselves as interns and residents in primary care who were fulfilling a rotation in,

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[15] The articles were published between 1968 and 2013. During the first stage of searching for articles to comprise my corpus, I selected as a "begin date" January 1, 1970 and an end date June 30, 2013. This time span can be correlated to the proposal of the medicalization thesis and to implementation of legal forms for patients to "negotiate" death in advance. It also represents approximately a generation of physicians. However, my initial search of U.S. medical journals did not yield personal essays/reflections/stories dating back to 1970; the earliest was published in 1978 in the *American Journal of Medicine*. *BMJ* began publishing British physicians' personal writing in 1968. In Chapter 4, I examine reasons why American medical journals waited until 1978 to publish physicians' personal writing.

[16] Narratives published in the *Journal of Clinical Oncology* form a small corpus that I foresee using in a follow-up study in which I will compare results from the present investigation to death telling by physician-trainees in oncology who expect to regularly confront dying patients. This research may provide further insight to the understanding of narrative as a rhetorical response to the exigence of death.

rather than intentionally pursuing the specialty of, palliative medicine. Texts in two other journals published by a medical specialty also were identified: 11 narratives in *Annals of Emergency Medicine* and 9 in *Academic Emergency Medicine*. I retained these texts in the corpus, since emergency medicine is relied upon by an increasing number of patients as their source of primary care, so emergency physicians often practice as generalists.[17] Several physician-trainees referenced in this corpus write about experiences in hospital emergency departments where they have developed long-term relationships with returning patients. The fifth journal that did not meet the criterion for a general medical journal, *Medical Economics*, was deleted from the corpus. Only one narrative had been found in the journal, which suggested that its publication might have been an anomaly rather than a representative sample of a recurring type of article.

Two other journals were identified in the PubMed search as core clinical journals, although only one was retained for the collection. Three articles were initially found in *The Lancet,* a well-known British medical journal that is read internationally. The articles appear in a section entitled "Uses of Error" in which the editors solicit "examples of mistakes from which [physicians] have learned lessons" (Horton, 2001, p. 88). Accordingly, the authors recount their experiences with a specific rhetorical purpose; their narratives function more as "confessionals" (Wear & Jones, 2010) than reflections. For this reason, they were not included in the corpus. In contrast, four narratives found in *Health Affairs*, a journal described on its website as focusing on "important public policy issues," were included. They appear in a section entitled "Narrative Matters" where they

[17] The practice of emergency medicine is described in the *Annals of Emergency Medicine* as "a forever-expanding bubble that encompasses every aspect of medicine…we as emergency physicians must know a lot about everything" (Shah, 2007, p. 476).

function as "policy narratives": "personal stories about experiences [that]…highlight important public policy issues" (Health Affairs, 2015). The section is supported in part by funding from the nonprofit W.K. Kellogg Foundation, which has enabled the journal to supplement print versions of the narratives with podcasts on iTunes. National Public Radio also regularly features selections from "Narrative Matters." Furthermore, the journal published an anthology of its personal narratives, *Narrative Matters*, in 2006. Not only does *Health Affairs* reach a wide general audience; the journal brings public and professional attention to the role of narrative in health and medicine with its section title and anthology.[18]

As a final check to ensure that the journals selected were in fact widely read, I used each publication's "impact factor" as triangulation. Impact factor is "a measure of the frequency with which the 'average article' in a journal has been cited in a given period of time" (CiteFactor.org, 2014). The measure, usually determined over a three-year period, "is used as standard dimension and the relative importance of a scientific journal within its field." Impact factors for journals in this study's corpus were obtained from *Medical Journal Impact Factors 2013* (published online by impactfactor.weebly.com) and several of the journal websites.

Table 3.1 ranks journals from highest to lowest in terms of impact factor. It should be noted that the impact factors of the 14 journals cluster into three groups: 4 of the journals are among medicine's highest impact journals; 7 journals are in a middle range (8.2-3.278); and 3 journals are in the lowest range (1.408-1.861). This distribution

[18] Two other journals have published collections of physicians' essays previously printed: *On Being a Doctor 2* (Lacombe, 2000) published in 2000 by the American College of Physicians which publishes *Annals of Internal Medicine*, and *The Wonder and the Mystery* (Gotler, 2013) published by *Annals of Family Medicine.* The latter includes a text from that journal that is part of this corpus (Glazer, 2004).

Table 3.1: Journal Comparison by Impact Factor

Journal	Impact Factor
The New England Journal of Medicine	53.298
JAMA (Journal of the American Medical Association)	30.000
Annals of Internal Medicine	16.733
BMJ (British Medical Journal)	14.093
CMAJ (Canadian Medical Association Journal)	8.217
American Journal of Medicine	5.430
Annals of Family Medicine	5.355
Health Affairs	4.313
Family Medicine	4.140
Annals of Emergency Medicine	4.133
Journal of General Internal Medicine	3.278
Academic Emergency Medicine	1.861
Journal of Palliative Care	1.849
Canadian Family Physician	1.408

From *Medical Journal Impact Factors 2013* and journal websites.

suggests the corpus is a representative sample of the range of available medical journals, from those widely read by all physicians (e.g., *The New England Journal of Medicine*) to journals read primarily by physicians practicing in a particular area of primary care (e.g., *Academic Emergency Medicine*). [19]

Data Analysis

I used four unique methods to analyze the data or study corpus: discourse analysis, narrative discourse analysis, rhetorical genre analysis, and a synthesis of material rhetoric and phenomenological analysis. In addition to describing each method in the subsections that follow, I include background literature on the method and justification on the selected methodologies.

Discourse Analysis: Rich Features

For the first stage of analysis I used discourse analysis as a qualitative inductive methodology. I intend *discourse* as Ruth Wodak and Michal Krzyzanowski define it in *Qualitative Discourse Analysis in the Social Sciences*: "'the social activity of making meanings with language and other symbolic systems in some particular kind of situation or setting…[which are] more or less governed by social habits, [and] produce texts that will in some ways be alike in their meanings" (2008, p. 6). The authors differentiate between *discourse* and *text* by noting, *"[d]iscourse* implies patterns and commonalities

[19] My selection of journals was further validated by an editorial in the November 6, 1997, issue of *The New England Journal of Medicine*, in which physician-editor Marcia Angell and James Kassirer names the five "largest" general medical journals. Her list includes the four journals shown as the top tier in Table 3.1. *The Lancet*, considered but deleted from my corpus, was identified by the editors as the fifth journal on the list.

of knowledge and structures whereas a *text* is a specific and unique realization of a discourse. Texts belong to genres" (p. 6). Accordingly, individual articles written by physicians will be considered texts; the writing process through which doctors create the texts and their meanings will be considered discourses.

I began my analysis by following Ellen Barton's process of "rich feature analysis" (2002, p. 27), an inductive discourse analysis procedure adapted from Thomas Huckin's contextual analysis (1992). I read physicians' texts "holistically, looking for general patterns" (Huckin, 1992, p. 91). These included the absence of standard scientific formatting (introduction, methods, results, discussion); use of first-person, as opposed to third-person; and the predominant use of active voice. I then performed close readings of the corpus to verify these patterns and then to notice other prominent semantic patterns. Huckin refers to these as "salient patterns": "an unusual pattern of language use, a sharp deviation from some putative norm" (p. 90). Barton expands the concept by positing "rich" features, "linguistic features that point to the relation between a text and its context" (2002, p. 23). Rich features are particularly appropriate to genre analysis, she points out, since "[m]eaning arises in large part out of the patterned use of these features…repeated within and across texts" (p. 24).

I identified five significant rich features--emotive language, metaphors, euphemisms, repetition, metadiscourse, and narrative[20] —that make physicians' personal writing conspicuous within and across the medical journals, drawing upon inductive discourse analysis and examples of rich features cited by other researchers working with medical discourse (Barton, 2005, 2007; Lingard, Garwood, Schryer, & Spafford, 2003;

[20] This rich feature is discussed separately in the next section.

Schryer, 2003, 2012; Schryer & Spoel 2005). I defined "emotive language" as the prevalence of language denoting as well as connoting affect, e.g., "I cried" or "my eyes became wet," respectively. The rich feature "repetition" encompasses the repeating of: single words or phrases; opening clauses (e.g., anaphora); deliberate sentence fragments; and whole structures, e.g., repetitions of sentences introducing paragraphs (i.e., parallelism). Metadiscourse is intended to include "'metadiscursive strategies'" (Johnstone, 2008, p. 165): "ways of making discourse be about discourse" in which "speakers can situate themselves outside their words" (p. 165). Of the seven types of metadiscourse first identified (Vande Kopple, 1985), I opted to focus on code glosses and validity markers. Code glosses include the use of quotation marks, dashes, parentheses, and italicized type to set off words from the authors' "to help readers grasp the appropriate meanings of elements in texts" (p. 84). Validity markers "express [the writer's] view of the validity of the propositional material [they] convey" (p. 84). These are explanations of or asides as to what the author is thinking/doing/saying at the time she is writing and include hedges (*might*, *perhaps*); emphatics (*clearly*, *it's obvious*); attitude markers (*surprisingly*, *unfortunately*); commentary (*as you can see*); and attributors (*according to*).

Discourse analysis proved to be a useful methodology, since it "provide[s] a descriptive basis for developing…'a growing appreciation of the complexity of the [professional] discourse'" (Segal quoted by Barton, 2004, p. 95). In the culture of medicine, discourse analyses "show the interpretive processes and overall patterns of an activity" (Roberts & Sarangi, 2005, p. 632). Relevant to my study, discourse analysis

also illuminates the reflexive relationship between text and context, and between physicians' personal writing and the medical journals in which they are published.

In addition to identifying discourse patterns within texts, inductive discourse analysis enabled me to discern the same patterns of rich features across the corpus of medical journals. These findings allowed for an analysis of the relationship between text and context, since rich features "both reflect and shape its context" (Barton, 2002, p. 24). Thus, to fully investigate the function of rich features in physicians' writing, I examined the medical journals' stated goals for the sections in which the texts appeared as well as authors' submission guidelines provided by the journals, both of which defined the context. This investigation, then, led me to editorials and columns announcing the introduction of the journal narrative sections, providing an even richer and deeper view into the reflexive nature of text and context.

Narrative Discourse Analyses

While a narrative has been defined as a sequence of events that make up an individual's actual experiences, which usually are related in the order in which they occurred, I used a more recent revision of personal narrative: "a way of using language or another symbolic system to imbue life events with temporal and logical order, to demystify them and establish coherence across past, present, and as yet unrealized experience'" (Ochs & Capps quoted by Johnstone, 2008, p. 155).

Narrative discourse analysis was created by Labov who, with Joshua Waletzky, collected oral versions of "personal experience narratives" (1967, p. 12) and developed a narrative analytic structure from them. I drew upon Johnstone's definitions of the six

elements, adapted from Labov and Waletzky (2008): 1) the *abstract,* which is one of two clauses at the beginning of narrative that summarizes the story; 2) the *orientation*, which follows by introducing the characters and establishing the setting, time, and place of the narrative; 3) the *complicating action*, which is "the point of maximum suspense" (p. 93); 4) the *result* or *resolution*, which tells what finally happened; 5) the *evaluation*, which either announces or reiterates why the narrative is interesting, specifically why the audience should keep reading or listening and; 6) the *coda,* which announces the end of the narrative and may summarize the narrative or connect it to the events in the present.

Narrative Analysis Process

I began my narrative discourse analysis by randomly selecting 20 narratives from two journals, one that included narratives early on—an "early adaptor"--and one that added narratives within the last decade. I analyzed each text in terms of the six elements, using a template I developed for the analysis (see Appendix A).[21] From this initial sampling, I noticed recurrences, which prompted me to parse two elements that might provide additional, useful details. Under orientation, I specified whether the narrative took place during a night shift or "call" when physician-trainees work longer hours than average and sleep significantly fewer hours, which can affect their attitudes and behaviors. Under complicating action, I distinguished between six procedures and/or events that had reoccurred in the sampling. Each represents a distinct action or situation

[21]Although I have made every effort to be as objective as possible in analyzing physician-trainees' narratives, I believe Johnstone's words are worth quoting here: "bear in mind that this kind of work is inevitably interpretive. No discourse analyst can make definitive claims about the function of one or another element in story (or any other text), because the speaker's words, as captured in this transcribed text, constitute only one of many elements of the situation in which these words were uttered, understood, and reacted to" (2008, p. 94).

related to dying and death: pronouncing, or verifying, a death; experiencing a death for the first time; witnessing a relative's death; delivering bad news to surviving family members; confronting a dying/dead body; and confronting medical futility.

Similar to other researchers (Ozyildirim, 2009; Shiro, 2003, 2009) my initial analysis yielded too much irrelevant information to my questions. Labov's framework was considered too formal and detailed. In my case, the level of detail did not help me better understand why the narrative was written, or what its purpose could be. In response, I revised my narrative analysis template (see Appendix A) to enable me to check for and differentiate between three types of evaluative clauses--emotional/psychological, existential/ontological, and professional/social—that would enable me to determine why the narrative was told and why it should matter to the reader. I also added two events to those listed under complicating actions--encountering death in a foreign/developing country; and discussing code status--which I found reoccurring in the remainder of the corpus. Most importantly, I reframed complicating actions in terms of narrative preconstruction (Labov, 2007), which enabled me to more accurately discern genre knowledge--what is (in)articulated in medicine's hidden curriculum—and understand physicians' narratives, individually and collectively, in relationship to genre knowledge.

Narrative Preconstruction

Before beginning, a narrator must decide whether an event is "tellable" or "reportable," that "it does not happen every day, as a product of every-day activities" (Labov, 2007, p. 48); it is an occurrence out of the ordinary. A quick scan of my list of

complicating actions showed that each event was *not* reportable: even though interns and residents can, do, and should expect to experience these events (e.g., verifying a patient's death) during their clinical training. To understand this seeming contradiction, Labov explored "cognitive operations that operate in reverse order, the narrative *pre-construction* that every narrator must accomplish before beginning the narrative itself" (2007, p. 47). The narrator looks back "from the reportable event to a preceding one, driven by the need to answer the question 'How did that happen?'" (p. 48). A preceding event is likely "to emerge as more reportable than the one that was first selected," which Labov claims is important because it reveals narrative as "a product of complex interactions in the social environment" (p. 49). In my research, verifying death is a routine medical procedure in a teaching hospital. However, by looking backward in the narrative, I could search for a preceding event, which would yield information regarding the author's intention that would signal why the trainee recounted this particular "unreportable" death "reportable."

Thus, by readjusting my analytic lens, I was able to gather data from the narratives so as to distinguish between reportable and unreportable events, which enabled me to analyze specific encounters with death that compel trainees to want and/or need to make sense of these experiences professionally and personally. In other words, this additional step enabled me to separate out actions related to dying patients and death that are usually combined and generically referred to as "end of life." Thus, using narrative preconstruction as a methodological framework illuminated aspects of medical education, specifically, clinical training of interns and residents, which did, or did not, prepare them

emotionally and ontologically, as well as professionally, to provide effective and satisfactory patient care at the end of life.

Rhetorical Genre Analysis

To examine physicians' texts as a potential new genre of medical discourse, I used discourse analysis to determine thematic and rhetorical patterns across all individual texts and then applied Berkenkotter and Huckin's (1995) sociocognitive theory of genre, relevant because of its focus on disciplinary communication.

Carolyn Miller, in her landmark 1984 article, "Genre as Social Action," lays out what has become the foundation for rhetorical genre studies in the United States. She argues that "a rhetorically sound definition of genre must be centered not on the substance or form of discourse but on the action it is used to accomplish" (p. 151). Writers write in response to an exigence, construed as a form of social action. "The exigence," she explained, "provides the rhetor with a socially recognizable way to make his or her intentions known. It provides an occasion, and thus a form, for making public our private versions of things" (p. 158). Miller's conceptionalization of exigence, then, provides a useful framework for examining physicians' personal texts within medical discourse where they respond to "an objectified social need" identified by medical journals and function as "social knowledge" about the practice of medicine. Miller's theory affords genre the capability to "serve as keys to understanding how to participate in the actions of a community" (p. 165), in addition to distinguishing between rhetorical purpose -- why journals publish narratives—and rhetorical intention—why physicians write and publish narratives, or, succinctly, how they are responding to an exigency.

Berkenkotter and Huckin's sociocognitive theory of genre "examine[s] both the situated actions of writers, and the communicative systems in which disciplinary actors participate" (1995, p. ix). Combined, they enable the researcher "to engage in both microlevel and macrolevel analyses and to develop a perspective that reflects both foci" (p. ix). Using this framework, then, I could view physician-trainees as actors within the discipline of medicine, "*insiders*" of the communicative system (p. 2), who use personal narratives "for particular rhetorical purposes" (p. 2) within general medical journals, central sites of knowledge production in medicine's communicative system. As the theorists note, "Genres are the media through which scholars and scientists communicate with their peers…they package information in ways that conform to a discipline's norms, values, and ideology. Understanding the genres of written communication in one's field, therefore, is essential to professional success" (p. 1).

Salient Discourse Themes

When I performed discourse analyses of individual texts to discern rich discoursal features, I noted on each text the overarching emotional or psychological theme of each article. I returned to these themes at this stage of my analysis to determine whether any patterns emerged on the corpus level. I identified 11 recurrent affective themes, which were independent of complicating actions, the remarkable routine medical encounters that prompted the telling. I did not correlate the themes to the temporal setting of the articles or the time of publication. Instead, I found in examining descriptions of the physician-trainees' emotions and psychological states of mind recurring statements that challenge the taken-for-granted medical practices in the culture of medicine. I identified

10 types of challenges, which I then grouped into two broad categories of genre knowledge: *information physicians need for the treatment of and attention to patients at the end of life.*

To validate that these recurrent challenges qualified as genre knowledge and that the discourse about physician-trainees' experiences with nearly and newly dead patients constituted a rhetorical genre, I evaluated the discourse using the five principles of Berkenkotter and Huckin's sociocognitive theory of genre (Berkenkotter & Huckin, 1995). The first principle, or genre claim, is dynamism, which means that genres "are developed from actors' responses to recurrent situations and that serve to stabilize experience and give it coherence and meaning" (p. 4). Situatedness, the second principle, states that genres are "derived from and embedded in our participation in the communicative activities of daily and professional life" (p. 4). Genre knowledge is "transmitted through enculturation as apprentices become socialized to the ways of speaking in particular disciplinary communities" (p. 7); genres are also responses to an exigency of a situation. Form and content, the third principle, defines genre knowledge in more specific terms as "a sense of what content is appropriate to a particular purpose in a particular situation at a particular point in time" (p. 4). It also incorporates two important qualities: "surprise value" (p. 15), meaning that reported information much be novel, and *kairos*, understood as "rhetorical timing" in which rhetors take advantage of an opportune time to make their argument or use the timing of events to influence their argument. The fourth principle, duality of structure, refers to how "we *constitute* social structures (in professional, institutional, and organization contexts) and simultaneously *reproduce* these structures" (p. 17). Genres can be examined as constituting a significant social structure

in medicine, while physician-authors as social agents simultaneously generate practices that make up the structure. Further, this principle suggests that physicians also may constitute the possibility of a new social structure of medicine, which their personal texts simultaneously constitute. Community ownership, the fifth principle, is defined as "a discourse community's norms, epistemology, ideology, and social ideology" (p. 21) that are "signaled" by examining the community's discourse for "textual practices," the "textual features and rhetorical conventions" (p. 22). In other words, the rich features previously identified through discourse analysis can be re-examined along with results from the genre analysis, which together provide insight into medicine's beliefs and values regarding the care of dying patients.

Sociocognitive theory of genre, then, provided a useful and valuable framework with which to rhetorically analyze physicians' personal writing at micro- and macro-levels in order to examine how the significance of the texts extends beyond the expression of personal experiences to the generation of disciplinary knowledge relevant to the medical profession. The theory's five principles served as a methodology with which to examine physicians' personal writing as a dynamic rhetorical form emerging from the individual responses of physician-trainees to recurrent near-death situations, in addition to examining at the macrolevel how personal writing gives coherence and new meaning to physician-trainees' experiences within the larger communication system of medicine. The methodological framework also illuminated genre knowledge the institution of medicine tacitly teaches trainees, and how trainees' texts can (re)structure the institution for themselves. Finally, rhetorical genre theory as a methodology elucidates how textual practices, features, and conventions of physicians' personal

writing reveal multiple and conflicting ideologies surrounding dying and death.

Summary

The data collected for this study—physician-trainees' personal accounts of experiences with dying patients they encountered in their professional practice of medicine—represent a unique collection of texts. Solicited by and published in medical journals, the texts are subjective accounts of personal experiences, juxtaposed to the standard objective articles about original research that are foundational to the practice of medicine. Thus, the personal articles represent a rich and as yet unexamined resource for rhetorical analysis of disciplinary communication at the levels of individual texts, medical discourse, and genre studies.

Accordingly, multiple analyses were performed to examine the data or study corpus. These included discourse analysis of individual texts to identify rich features across the discourse; narrative discourse analysis of the data's dominant rich feature, personal narrative; and rhetorical genre theory used as a framework with which to analyze the viability and veracity of the study corpus as another genre of medical discourse.

CHAPTER 4

THE MATTER OF THE CORPUS

Introduction

In this chapter I argue that both the discourse of physicians' personal accounts of their experiences with dying and dead patients, and the publication of these subjective accounts alongside objective, scientific articles in medical journals are discursive responses to the exigence posed by a new understanding of death. Findings substantiate the occurrence of an unidentified rhetorical situation in medicine and argue for a new genre that responds to the exigency posed by this situation. Physicians-in-training do encounter end-of-life situations with patients for which they are emotionally and/or existentially unprepared, and about which many write and publish accounts of at some point in their careers. The collection of texts that comprise the corpus provides foundational data that ground my argument for a new genre and subgenre of medical discourse, *perspective writing* and *necrography*, respectively.

This genre and subgenre result from a confluence of social, political, and medical events that occurred in the United States and Great Britain during the mid- to late 20th century. These events increased the biomedical and social authority of medicine, including a perceived new power over death. Dying was transformed from a naturally occurring life event into a medical "problem" that physicians were trained, and expected,

to manage, if not solve usually through technological interventions. The earliest articles date back to 1968 when new editorial sections featuring physicians' personal writing were added to medical journals in Great Britain and the United States. Thereafter, they increased in number and in the journals that published them. These trends, then, lay the groundwork for addressing my first research question:

> ***RQ #1:*** *How does necrography, a subset of perspective writing, function as a rhetorical response to the exigence that death poses for the practice of medicine by physician-trainees?*

The Making of a New Rhetorical Situation

To demonstrate the exigency to which trainees were responding, I first identify three articles from medical journals that exemplify how the subject of death and dying has been temporally situated in medicine. These texts serve to punctuate the timeline as points of reference. I then present a timeline I created, a common research practice in the discipline of medical ethics of establishing a chronology of major social, legal, and cultural events relevant to an issue, a context within which to situate an argument.[22] On the timeline, I include events that influenced American and British medical research and practice; writing about medical matters; and attitudes of physicians and laypersons toward death. In my discussion, I highlight selected events that I have grouped into two

[22] Medical ethics or bioethics has been described as "a practical moral philosophy" (Jecker, Johnsen, & Pearlman, 2012, p. 13). The academic discipline evolved in response to moral questions, particularly those raised by "accelerated technological advances in modern medicine" (Rhodes, Francis, & Silvers, 2007, p. 1). These questions center on issues that cross disciplines—sociology, political science, anthropology, economics—which has resulted in an integrated approach to research. There is no one methodology used in medical ethics. Several approaches (e.g., casuistry), require researchers to consider moral judgments in terms of similarity to previous situations and cases (Beauchamp & Childress, 2001), which suggests that timelines are an invaluable research tool: an argument that is applicable in the examination of medicine in terms of rhetoric.

categories—scholarly research in clinical settings and scholarly research outside clinical settings—that led to a rhetorical situation, which, according to Bitzer (1968), is a "natural context of persons, events, objects, relations and an exigence which strongly invites utterance" (p. 5).

Historical Touchstones: Three Attitudes Toward Death

Each of the following three articles illustrates a unique rhetorical situation with a unique exigency regarding death, helping understand the contemporary situation into which trainees enter.

Article I

Decades before the definition of "brain-dead" would problematize death as a natural biological event, newly dead patients challenged physicians. In the July 25, 1925, issue of *BMJ*---at that time, *The British Medical Journal*—the "Correspondence" section included a letter and response entitled "Death Certification." At issue was "premature burial," a problem not uncommon in those days in which a person presumed dead was in fact buried alive. The physician-author proposes that "the doctor shall inspect the naked body of the deceased *the day after death,* when more manifest signs will have had time to develop, and, being satisfied, shall certify accordingly" (Good, 1925, p. 178; emphasis added). The physician asks colleagues to "reflect upon the fact that death of the whole body is a gradual process occupying a definite lapse of time, although the suspension of the vital faculties may appear to be sudden and complete?" He ends end his statement with a question mark, which is a significant rhetorical choice in the context of this study,

since it evinces the beginning of a perceptual shift. Death as a biological determination physicians could conclusively make by performing a medical procedure was being challenged.

Article II

The second noteworthy article was published in a 1963 issue of another leading British medical journal, *The Lancet*, also widely read in the United States. Lord Robert Platt, who in 1968, was the first physician-author featured in *BMJ's* new section, "Personal View," reflects on aging and death: "Lay people are naturally interested to know a doctor's view on what he should tell his patients; but, in fact, the question does not arise as often as they think. For a conspiracy of silence usually surrounds the whole question of death, a silence as much due to the patient's avoidance of the subject as the doctor's" (Platt quoted by Aring, 1968, p. 152). He concludes that to even bring up the topic of death is inappropriate.

Article III

Charles D. Aring, the physician who quotes Platt above, does so to establish physicians' conflicted relationship with death. Aring writes a "special article" in a 1968 issue of *Annals of Internal Medicine*, which he had presented as a paper 2 years prior at the symposium "On Death in Medicine" at Case Western Reserve University. He argues for "a new and hopefully realistic look" at "death and dying [that] have been taboo" (Aring, 1968, p. 138). He warns that "it is but a step to assign inferiority to the dying….They die, ergo, they are not human, *are* inferior: thereby we deny that we who

are human must ourselves die" (pp. 144-145; emphasis in original). Directing his comments toward trainees as well as colleagues, the physician explains, "Dying and death can become natural if you and I will make it so"; "The graceful use of the self is what is needed, and one cannot use oneself with grace if his energies are spent in quelling inner turmoil" (p. 149). Historically, then, even as a "taboo" topic, death has been an *exigence* in the culture of medicine: it provides for Aring a "socially objectified motive" (Miller, 1968, p. 158) for analyzing the way in which death creates a "separateness" between doctor and dying patient as human beings, and for finding a resolution to this problem.

Moreover, Aring's article stands out for two other reasons critically relevant to this study: 1) his argument for the value of personal narrative in medicine and 2) his prescient perception of the impact of technology on humanistic medical care. Regarding narrative as a rhetorical strategy, the physician writes: "Following my own prescription, I will examine the problem [of death] with an analysis of the development of my attitudes, citing experiences" (1968, p. 139). He describes witnessing the deaths of his mother when he was 6 years old and of several patients later in his career; he also quotes a letter that his son, a medical student, had recently written him, describing his first experience with a dying patient. Aring argues that personal experience is essential for physician-trainees to draw upon in learning how to care for patients, living as well as dying, so as to counteract the "mechanistic and laboratory orientation of medicine" (p. 139). This latter phrase is, in essence, the medicalization thesis that had not yet been proposed by social critics.

Physicians' changing perceptions of dying patients and their troubling conceptions of death presented medical practitioners with an exigence or "social motive" (Miller, 1984, p. 158); "a set of particular social patterns and expectations that provides a socially objectified motive for addressing danger, ignorance, *separateness*" (p. 158; emphasis added). Aring, the physician-author, also uses the same word, *separateness*; he describes how doctors in the 1960s viewed dying patients as distinctly apart from them. Interestingly, *separate* is distinguished from its synonyms by implying that what was once "united" or "joined" (*Webster's New World Dictionary*) is now set apart. Death historically united human beings, as discussed in the introduction to this dissertation. Medicalization, however, has encouraged physicians to view themselves apart from patients as well as to deny the inevitability of death through medical interventions.

A Timeline of Events Influencing American and British Medical Research and Practice

The timeline in Table 4.1 more fully illustrates the social, political and cultural trends that increasingly led to a questioning of the inevitability of death. As noted earlier, *BMJ* introduced the first journal section for physicians' personal writing, "Personal View," in 1968; the first U.S. medical journal to launch a similar section, "Medicine, Science, and Society," was the *American Journal of Medicine* in 1978. Note the trend toward more pointed titles regarding death, and the establishing of sections of medical journals dedicated to personal stories set in professional contexts.

Table 4.1: Timeline of Social, Political, and Cultural Events Influencing American Attitudes Toward Dying and Death: Addition of New Sections in Medical Journals Highlighted

YEAR	EVENT
1960s	• "Age of Delayed Degenerative Diseases" (Olshansky & Ault 1986): shift in disease patterns and transition in causes of death
1965	• Psychiatrist Elizabeth Kübler-Ross begins 2-year study of stages at dying at University of Chicago
1967	• Physician-social worker Cicely Saunders opens St. Christopher's Hospice in London, England • "Living will" concept proposed by Chicago lawyer Luis Kutner
1968	• ***BMJ* introduces section "Personal View"** • 1st U.S. board-approved training program in geriatrics launched at nursing homes
1969	• Kübler-Ross publishes *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Their Own Families*
1970	• "Medicalization thesis" introduced by sociologist
1974	• Michel Foucault publishes *The Birth of the Clinic: An Archaeology of Medicine Perception* in France • Surgeon Richard Selzer publishes essay collection, *Mortal Lessons: Notes on the Art of Surgery* • Neurologist Oliver Sacks publishes book on patients with neurological disorders, *Awakenings* • First U.S. Hospice introduced at Yale-New Haven Hospital
1976	• California passes Natural Death Act allowing legal directives to terminate medical treatment • Karen Ann Quinlan case on end-of-life court ruling
1977	• *Washington Post* runs article by couple whose dying daughter treated at English Hospice; Cicely Saunders follows with column in *American Journal of Medicine* • Ernest Becker publishes *The Denial of Death*
1978	• ***The American Journal of Medicine* begins section "Medicine, Science and Society"** Samuel Shem (pen name for physician Stephen Bergman) publishes fictitious account of medical residency, *The House of God*
1980	• ***JAMA* begins "A Piece of My Mind"**
1981	• Philippe Aries publishes *The Hour of Our Death: The Classic History of Western Attitudes Toward Death Over the Last One Thousand Years* in France
1984	• Physician David Hilfiker publishes essay acknowledging a medical mistake that resulted in fetal death, "Facing Our Mistakes" in *The New England Journal of Medicine* • Death of Libby Zion allegedly due to underworked and undersupervised residents examined in *JAMA* • Anesthesiologist and lawyer Jay Katz publishes *The Silence World of Doctor and Patient* about informed consent

Table 4.1: Continued

YEAR	EVENT
1985	• Neurologist Oliver Sacks publishes essays about unusual patient cases, *The Man Who Mistook His Wife for a Hat*
1986	• ***Journal of General Internal Medicine*** **begins "Reflections"**
1987	• Pediatrician Perri Klass publishes memoir about medical school, *A Not Entirely a Benign Procedure* • Family physician Howard Brody publishes *Stories of Sickness*
1988	• Physician Arthur Kleinman publishes *The Illness Narratives: Suffering, Healing, and the Human Condition*
1990	• U.S. Congress passes Patient Self-Determination Act giving all citizens legal right to have advance directives • Nancy Cruzan legal case on end-of-life care
1990-98	• Pathologist Jack Kevorkian illegally assists terminally ill patients in carrying out suicide
1991	• Kathryn Montgomery Hunter publishes *Doctors' Stories: The Narrative Structure of Medical Knowledge* • ***Annals of Internal Medicine begins "On Being a Doctor"***
1992	• Author and cancer patient Anatole Broyard publishes essay collection *Intoxicated by My Illness and Other Writings on Life and Death* (selections previously published in *The New York Times*) • Perri Klass publishes memoir of her pediatric residency, *Baby Doctor*
1993	• ***Annals of Emergency Medicine*** **begins "Change of Shift"**
1994	• Publication of seminal article on medical education and training, "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education" by medical sociologist Frederic W. Hafferty, Ph.D., and medical school dean Ronald Franks, M.D. • Surgeon Sherwin B. Nuland publishes *How We Die: Reflections on Life's Final Chapter* • Physician Abraham Verghese publishes memoir about caring for AIDS patients, *My Own Country: A Doctor's Story* • English translation of Michael Foucault's *The Birth of the Clinic* published
1995	• Medical sociologist Arthur W. Frank publishes *The Wounded Storyteller: Body, Illness, and Ethics* • Results from SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments), a multicenter clinical trial on end-of-life care in the U.S., are published in *JAMA*
1997	• Oregon Physician-Assisted Suicide Statute passes legalizing physician-assisted suicide for terminally ill patients

Table 4.1: Continued

YEAR	EVENT
1998	• ***CMAJ* begins "Experience"** • ***Family Medicine* begins "Lessons from Our Learners"** • ***Journal of Palliative Medicine* begins "Personal Reflection"**
1999	• ***Health Affairs* begins "Narrative Matters"** • Anne Hunsaker Hawkins publishes *Reconstructing Illness: Studies in Pathography* • ***Canadian Family Physician* begins "Residents' Page"**
2002	• ***NEJM* begins "Perspective"/"On Becoming a Physician"** • Surgeon Atul Gawande publishes memoir, *Complications: A Surgeon's Notes on an Imperfect Science*
2003	• ***Annals of Family Medicine* begins "Reflections"** • Internist Danielle Ofri publishes memoir about medical training, *Singular Intimacies: Becoming a Doctor at Bellevue*
2005	• Terry Schiavo landmark end-of-life court case
2006	• Internist and literature scholar Rita Charon publishes *Narrative Medicine: Honoring the Stories of Illness* • ***Academic Emergency Medicine* starts "Resident Portfolio"**
2007	• Medical anthropologist Sharon R. Kaufman publishes ethnography, *And a Time to Die: How American Hospitals Shape the End of Life* • Surgeon Pauline Chen publishes essay collection *Final Exam: A Surgeon's Reflections on Mortality*
2009	• Public debate about proposed end-of-life conversations referred to as "Death Panels"
2010	• U.S. Congress passes Affordable Care Act

Medical Mileposts Leading to a New Rhetorical Situation

Scholarly Research in Clinical Settings

As Table 4.1 shows, professional views toward death changed in the mid-20th century due in large part to new clinical research about dying patients. One of the most influential articles that later would prompt changes in medical training and practice, however, focused on the medical curriculum.

In 1965 Elizabeth Kübler-Ross, M.D., began one of the earliest and most significant clinical research projects on death when she arranged interviews for graduate theology students with dying patients at University of Chicago Hospital. In 1969, the psychiatrist published *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Their Own Families*, which remains a highly influential international book describing five stages of dying. At about the same time across the Atlantic, Dame Cicely Saunders, who had degrees in medicine and social work, opened in 1967 St. Christopher's Hospice in London, the first modern hospice in Britain.[23] It was not until 1974 that the first U.S. hospice was established in Connecticut near the Yale-New Haven Hospital. This 7-year difference may help account for the lag time between when the first British and American medical journals added new editorial sections for physicians' personal writing in 1968 and 1978, respectively. Saunders' hospice movement indicates that discussions regarding medical care of the dying were on-going in more concrete form earlier in Britain than in the United States.

Taken together, the events cited above (in addition to others on the timeline) evince a shift in professional views towards the medical care of dying patients described

[23] Hospices have operated since medieval times, offering shelter to travelers as well as the sick (National Hospice and Palliative Care Organization).

earlier in that decade by Aring in *Annals of Internal Medicine*. Dying patients became worthy research subjects, as opposed to inferior, inhuman beings. This conceptual shift, however, was not unanimously taken up by physicians. In 1995, the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) clinical trial documented resistance from physicians. In particular, the multicenter study found that "physicians' attitudes toward life and death and toward medical interventions and technology" (Gilligan & Raffin, 1996, p. 139) lagged behind those of patients and their families; doctors "largely ignored or were unaware of terminally ill patients' desire to be designated as do-not-resuscitate/do not intubate." The study also reported that "medicine's focus on pathology and physiology, on vital signs and diagnostic tests, may obscure the human context of the illness" (p. 139). Thus, we see talk about the dynamics between doctor and dying patient changing but not without contention.

An article that raised new criticisms of medical education as well as medical culture was "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education" (Hafferty & Franks, 1994), referenced in the introduction to this dissertation. It has been among the most significant reports on medical education and ethics, strongly influencing the professional practice of medicine, including end of life care.[24] In the journal *Academic Medicine*, published by the Association of American Medical Colleges (AAMC), Frederic W. Hafferty, a medical sociologist, and Ronald Franks, a physician and then dean of the University of Minnesota, Duluth School of Medicine, argued that medical trainees learn more about medical ethics through what they call the "hidden curriculum," the transmission of a "medical morality" (p. 865) tacitly taught through

[24] The article has been cited more than 940 times, according to a Google Scholar search in November 2014.

"informal processes such as 'general clinical experience,' peer interactions, 'ward rounds,' and 'role models,' rather than formal coursework in ethics or related topics" (p. 862). Their argument centers on a contradiction that is fundamental to the taken-for-granted view of medicine as an applied science. Medicine traditionally "views the knowledge base and application of science as value-neutral, 'objective,' and therefore transcultural" (p. 863). Yet, the discipline is not value-free. As the authors convincingly emphasize, medical training is an enculturation process that transmits "notions of rightness and wrongness, appropriateness and in appropriateness" (p. 863) that are shaped by "social and cultural matter." Not only is this aspect of the curriculum unacknowledged; it "often can be antithetical to the goals and content of those courses that are formally offered" (p. 865). As an example of the "inconsistencies, contradictions, and 'double-messages'" medical trainees confront in caring for dying patients is the didactic emphasis on the humanistic value of *caring* that conflicts with the behaviors trainees see modeled "in the hallways": "the 'dangers' of becoming 'too' involved" with patients; "a medical culture that discourages certain feelings, introspection, or personal reflection" (p. 866). The result of the hidden curriculum, according to the authors, is "moral relativism and cynicism regarding the sanctity of the standards that are supposed to govern [trainees'] professional lives" (p. 866), a situation that continues to prompt new course offerings in medical ethics, medical humanities, and professionalism correctives.

Scholarly Research Outside Clinical Settings

Research and scholarly projects documenting social changes outside the realm of medicine also have influenced directly and indirectly societal attitudes towards the institution and practice of medicine. For example, Olshansky and Ault (1986) identified what they called a new stage of epidemiologic transition dating to the mid-1960s: "The Age of Delayed Degenerative Diseases." The researchers found that overall rates of death among the elderly were decreasing, particularly due to degenerative diseases. "The health care community became increasingly successful in postponing deaths" (p. 359). As a result, rates for Americans' life expectancy at birth significantly increased as well.

At the same time that advances in medical technology--along with the development of antibiotics, public health campaigns, and more sophisticated tools for the diagnosis and treatment of diseases--were seen as improving survival, other sociologists were articulating the "medicalization thesis," which argues that technological advances invest too much power into the institution of medicine. Friedson (1970) questioned society's increasing trust in, and especially decreasing oversight of, physicians. Illich (1976) criticized the reach of medical jurisdiction, which redefined societal problems as medical problems, taking control away from individuals who had to rely upon physicians to fix the problems.

Two books on cultural history published in France during this time period further encouraged critical examination of medicine in general and death in particular. In 1974, Foucault published *The Birth of the Clinic: An Archaeology of Medical Perception* in which he re-envisioned medical science not as objective, unquestionable truth, but shaped by the vicissitudes of social and cultural forces. Foucault identifies the "medical gaze"

that reinforces the medicalization thesis by naming the powerful way in which medical professionals delimit patients' authority due to doctors' privileged position. In 1977, Philippe Aries published an ambitious study aptly described by its title: *The Hour of Our Death: The Classic History of Western Attitudes Toward Death Over the Last One Thousand Years*. The book, translated into English in 1981, is referenced by physician-authors in this corpus (see McCue, 1995).

New perceptions of death and the increasing jurisdiction of medicine helped bring about the "problem" (Aring, 1968) of death, to which the legal profession quickly responded. The concept of a "living will" was proposed in 1967 and published 2 years later in the *Indiana Law Journal* by Luis Kutner, a Chicago civil rights attorney, so that dying individuals could legally make known their wishes regarding medical care at the end of life (*Encyclopedia of Death and Dying*). Soon the term "living will" was supplanted by "advance directive," considered to better reflect the document's legal purpose: Individuals could choose in advance of terminal or life-threatening illness or mental incapacity, which medical procedures they would, and would not, want. With passage of the Natural Death Act in 1976, California became the first state to allow legal directives that would terminate medical treatments. In 1990, the U.S. Congress passed the Patient Self-Determination Act, giving all citizens legal access to advance directives.

While these new legal documents enabled patients to negotiate aspects of their dying, they did not fully or finally answer questions of patient autonomy regarding death. They also did not they define physicians' responsibilities in either prolonging life or hastening patients' deaths. In 1976, the New Jersey Supreme Court ruled in the landmark Karen Ann Quinlan case that the 21-year-old woman, who had remained in a persistent

vegetative state for 7 months after ingesting alcohol and drugs, could be disconnected from life support per her parents' request. Her physicians and the hospital had objected (Jecker, Jonsen & Pearlman, 2012). Yet in 1982, two physicians were charged with murder for withdrawing life support from a patient in an irreversible coma whose family had requested the termination (Lo, 1984). The physicians eventually were acquitted, but the case was discussed in medical journals and the media, reflecting the contested issues of dying and death in medicalized American society.

Likewise, the Libby Zion case of 1986 was examined in *The New England Journal of Medicine* as a case history of physicians' mistakes that allegedly resulted in a patient's death. Zion, the 18-year-old daughter of a New York lawyer who also was a *New York Times* writer, died unexpectedly in an emergency room from what her father said was "inadequate care in the hands of overworked and undersupervised medical house officers [intern and resident]" (Asch & Parker, 1988, p. 771). A grand jury did not indict the trainees, though it did criticize the graduate medical education system, which led to national reforms that shortened residents' working hours.[25] The medicalization of patient care was increasingly being questioned and redefined.

As the above cases illustrate, medicine had become newsworthy by the mid-20th century. "Medicine is the stuff of headlines" (Ingelfinger quoted by Podolsky, Greene, & Jones, 2012, p. 1461) wrote the editor of *The New England Journal of Medicine* in 1977. The Quinlan case in particular drew public attention to the practice of medicine and

[25] For an historical as well as personal perspective on the issue of resident working hours, see Gaufberg, 2008; her comments on work hours also are cited in Chapter 5 in the subsection on quotation marks. I discuss the effect of working long hours on trainees' psychological health and on their professional delivery of care in Chapter 5 in the subsection "Politically and Professionally Incorrect Feelings." The issue, however, is referenced directly and indirectly in many articles in the study corpus.

brought medical discourse—e.g., "chronic persistent vegetative state"—into the popular lexicon. Other news articles provided a behind-the-scenes glimpse into other aspects of medicine, such as clinical research findings, medical procedures, health policy, and medical insurance. Not only did the popular media increasingly feature articles about medicine, popular nonfiction bestseller lists frequently featured books by physician-authors who revealed the machinations of medical education and practice to lay audiences.

Surgeon Richard Selzer and neurologist Oliver Sacks published their first essay collections in the 1970s. In the 1980s, physician-authors Arthur Kleinman and Howard Brody independently examined the role of narrative and story in medicine, differentiating between *diseases* that physicians treat and *illnesses* that patients experience. In 1978, Samuel Shem (pen name of psychiatrist Stephen Bergman) published *The House of God*, a fictional account of graduate medical education. Now considered a classic, the book did not present medical practice as empathic, to say the least.[26] In 1987, pediatrician Perri Klass published *A Not Entirely a Benign Procedure: Four Years as a Medical Student*, an honest yet far less acerbic account of medical education. As evinced on the timeline, this trend in medical writing continued into the 1990s when physician-authors Jerome Groopman, Abraham Verghese, and Atul Gawande, among others, brought into public discourse other aspects of medicine in their roles as contributing writers to magazines such as *The New Yorker* and as authors of medical memoirs and essay collections.

[26] As evidence of the novel's continuing impact on medical education and training, The Kent State University Press published in 2008 *Return to* The House of God: *Medical Resident Education 1978-2008*, edited by Martin Kohn and Carol Donley.

Discursive Forums as Social Action

The confluence of events and people cited above — new clinical research in medicine that, for the first time, focused on dying patients, thereby altering dynamics in the doctor-patient relationship; scholarly research that documented and critically examined the increasing power vested in medicine by American society; legal documents and court decisions that shifted authority from physicians to the public, granting patients autonomy at the end-of-life; and public disclosure of the previously private world of medicine — created the material conditions for a rhetorical situation "so controlling" that it "demand[ed]" (Bitzer, 1968, p. 5) a discursive response that would alleviate, if not modify the exigence. The new conception of death was troubling to individual physicians who then wrote professionally about it in the context of their personal experiences. Likewise, medical journals, which play an essential role in the profession, were compelled to respond to the problem death had become for the medical profession.

Historically, the purpose of medical journals was "to be a medical school, a residency program, a clinical preceptor, a set of textbooks, and a medical society unto itself" (Podolsky, Greene, & Jones, 2012, p. 1458). Dissemination of knowledge, clinical as well as scientific research, was a top priority. As the public was afforded increasing insight into the profession's private realm, however, medical journals simultaneously were urged to "include 'exposure and discussion of important issues that involve, even indirectly, health and medicine'" (p. 1459). As the timeline in Table 4.1 suggests, these issues were not only political but also personal, especially when the debates, implicitly as well as explicitly, questioned the authority of physicians. Thus, medical journals functioned as "a social and moral community"; the publications "'furnish a bond of union

and sympathy between the members of our profession which nothing else can supply'" (p. 1459). As editors recognized that the practice of medicine necessitated more than scientific knowledge, the journals added sections and solicited personal writing that previously had appeared in journals only as correspondence, editorials, or special articles. This decision, I will argue, can be construed as a social action.

Professional Space for Personal Experience

Editors envisioned a critical social purpose for this new medical discourse, announcing the addition of physicians' personal writing in their journals. The announcements provide insight into why editors felt compelled to provide a discursive forum where physicians could write about their subjective experiences in professional settings. Originally, the corpus search dates were from January 1, 1970 to June 30, 2013. This time span correlates to the proposal of the medicalization thesis and to implementation of legal forms for patients to "negotiate" death in advance. It also represents approximately a generation of physicians. However, my initial search of U.S. medical journals did not yield personal essays/reflections/stories dating back to 1970; the earliest was published in 1978 in the *American Journal of Medicine*. *BMJ* began publishing British physicians' personal writing in 1968. I also did not find any journals adding sections after 2006, even though my end date was 2013 (this may be due to more contemporary technologies, such as blogging). I begin with the first four "early adopter" journals and follow with comments from the editors of selected journals.

BMJ (*British Medical Journal*)

In a column entitled "Into 1969," the editors noted two changes in the journal, "a glossy cover and a new feature called Personal View" (*BMJ*, 1968, p. 6). They explained that "contributors have been asked to reminisce and write about *their own* interests and enthusiasms. The flavour which we hope will come through is that of good conversation. The page is intended to provide a moment of relaxation between the sterner stuff on either side of it" (*BMJ*, 1968, p. 6l; italics added). "Personal View," literally sandwiched in the middle of the journal, was intended to give voice to physicians as individuals. The use of "sterner" to describe the majority of writing in the journal further is particularly apt; its negative connotations of "unyielding" and "forbidding" contrast with the permission granted to contributors to the new section who are encouraged to focus on themselves: to write freely, personally, and subjectively.

American Journal of Medicine

Like its British counterpart, the first American journal to add a section for personal essays intended for the writing to provide a respite from science; "a chance to pause and reflect" (Bearn, 1978, p. 406). The overall purpose of the section, "Medicine, Science and Society," however, was decidedly more serious in tone and content. As the physician-editor Alexander G. Bearn wrote:

> Today there is no need to extol the contributions of molecular biology to a more rational understanding of health and disease. The spectacular new knowledge gained during the last 40 years is sufficient testimony. Yet there remains an uneasy and mounting feeling that reductionism, powerful and effective though it will always be, is not enough…The impact of science and medicine on society as well as that of society on medicine raise issues of the greatest importance. These issues have been insufficiently discussed…In an effort to explore the complex interrelationships of medicine, science and society, we are initiating a series of

> editorials, forums if you will, for the discussion of important societal issues that affect our lives as *physicians, medical scientists and citizens*. (emphasis added)

I emphasize the above phrase because it significantly acknowledges that the profession of medicine segments physicians into three separate public beings, each affected differently by social issues. By the end of the century, journals will foreground the private, more personal aspect of their being. Moreover, the above introduction is significant for the editor reveals the "uneasy and mounting feeling" that science alone provides insufficient knowledge for physicians; that the practice of medicine is shaped by society *and* biology: a perspective few other editors explicitly state.

JAMA (*Journal of the American Medical Association*)

In his editorial announcing "A Piece of Your Mind," physician Samuel Vaisrub describes the new journal section by what it will *not* be, using florid prose that he cautions against:

> We hasten to assure readers that A PIECE OF MY MIND…is not intended as a sounding board for peevish gripes, nit-picking beefs, or sundry assortments of righteous indignations, which are usually prefaced by an angry 'let me give you a piece of my mind.' Nor is this section of THE JOURNAL meant to be a podium for pompous preachments and ex cathedra pronouncements. Nor again is it designed to be a forum for half-baked speculations and warmed-over hypotheses. Least of all is A PIECE OF MY MIND envisaged as a jamboree of jokes and a shivaree of limericks. (1980, p. 1845)

What the section will be is "an informal courtyard of creativity, in which physicians display vignettes of their nonscientific and not strictly clinical observations, experiences, reflections, and fantasies tinged with philosophy or humor" (p. 1845). Clearly, the reference to a "courtyard" fulfills the medical journal's purpose as a social community in which only those allowed inside can forge bonds of sympathy. "Courtyard" also implies

privilege: an enclosed space reserved for those with sovereign *authority*, which, in light of increasing social criticism of medicine, is indeed relevant. Thus, the description emphasizes the rhetoricality of the new section as socially constructed through material conditions.

Journal of General Internal Medicine

In the journal's inaugural issue in 1986, the editors begin with an endorsement of science: "We believe that the most important content of the JOURNAL should be reports of original research, the kind that can guide the practice of primary care/general internal medicine" (Fletcher & Fletcher, 1986, p. 59). However, two paragraphs later, they add, "Besides original research, other components belong in a well-balanced professional journal"; "In response to suggestions by many members, we will be including a section, 'Perspectives,' which places into a larger context our individual efforts as internists. A small part of the JOURNAL will be for 'Reflections': short essays on our lives, work, science, art" (p. 59). Nine years later in a call for submissions, different co-editors will narrow the focus and purpose of "Reflections": "While most medical journals strive to provide the knowledge and science for the practice of medicine, we hope to address the humanistic aspects of patient care" (Aronowitz & Jain, 2007, p. 892). In particular, the co-editors note that "[e]xperiences in health care, from the perspectives of doctors…elicit an emotional response sometimes ignored or left by the wayside for lack of time, focus, or audience," which they encourage physicians to both write about and read in the journal. Although an affective emphasis is explicitly announced in 2007, it is implicitly acknowledged in the first published articles, as will be shown in Chapter 5.

Later Editorial Descriptions

Below are descriptions from other medical journals that added sections in the next 2 decades, from 1990-2006. I have selected comments that highlight different goals or eloquently describe the aim of personal writing selected for publication.

- *Annals of Internal Medicine**:*** "Much of society's regard for the profession is rooted in the humanity of physicians and in the understanding that doctors are deeply involved in important life events of their patients: birth, serious illness, and death….Doctors, as well as patients, are profoundly affected by these interactions, in both positive and negative ways….The best writers remind physicians of the special meaning of being a doctor; perhaps such as reminder is particularly needed in these times of bureaucratic frustrations" (1990, p. 820).
- *Journal of Palliative Medicine**:*** "Awareness of personal feelings and understanding of their impact is particularly important when caring for patients at the end-of-life. The goal of the Personal Reflection Section is to allow caregivers to speak frankly about their experiences in caring for the terminally ill… in helping patients died a 'good death'—to openly address the stresses associated with caring for patients at the end of life" (1998, p. 89).
- *Family Medicine**:*** "Since its inception, the intent of this column has been to bring to the attention of family medicine educators the perspectives of our learners." "It is not important if it was something that happened yesterday or some time ago. Through our shared experiences, we might all learn to become better teachers and learners."

- *Academic Emergency Medicine**:*** "One may question why *Academic Emergency Medicine* would feature resident portfolios that seem to disproportionately dwell on negatives…themes of ambivalence, uncertainty, and challenges to the young professional. Ignoring these issues will not make the issues less real….[W]hat are our (the academic community's) contributions to this process, and can we address this through the selection and preparation process?....Can we trace the seeds of frustration to medical school? If so, do we reinforce those biases during their EM experiences?" (Chisholm, 2009, p. 567).

To understand why medical journal editors felt compelled to add sections reserved for personal writing distinct from discourse in letters to the editor and opinion columns, I created Table 4.2, which lists the new sections by journal and title. Many of the section names reflect the historical purposes of medical journals, a tradition the new sections carry on. "Lessons from Our Learners" illustrates the journal as medical school; "Residents' Page" and "Resident Portfolio," the journal as a residency program and clinical preceptor. "Medicine, Science and Society" shows how the journals serve as public forums for important issues, while "Personal View," "A Piece of My Mind," and "Personal Reflection" highlight how journals strengthen bonds between physicians in their role as a social community.

Most notable, however, are the titles that allude to a *new and expanded* function of medical journals as moral communities: "On Being a Doctor," "Change of Shift," "Narrative Matters," and "Becoming a Physician." These titles connote the moral enculturation that medicine imposes upon trainees, namely, that "being a doctor" implies

a different type of existence. "Becoming a Physician" means, in terms of the hidden curriculum, "learning how to 'cease' to be lay person"; "it is about the acquisition of a physician identity and character" (Hafferty & Frank, 1994, p. 865). To be a physician is to enact "separateness"; to exist apart from all other human beings, which necessitates a

Table 4.2: Journals and New Section Titles

JOURNAL TITLE	SECTION TITLE	YEAR SECTION ADDED
BMJ	Personal View	1968
American Journal of Medicine	Medicine, Science and Society	1978
JAMA	A Piece of My Mind	1980
Journal of General Internal Medicine	Reflections	1986
Annals of Internal Medicine	On Being a Doctor	1991
Annals of Emergency Medicine	Change of Shift	1993
CMAJ (Canadian Medical Association Journal)	Experience	1998
Journal of Palliative Medicine	Personal Reflection	1998
Family Medicine	Lessons from Our Learners	1998
Health Affairs	Narrative Matters	1999
Canadian Family Physician	Residents' Page	1999
New England Journal of Medicine	Perspective/Becoming a Physician	2002
Annals of Family Medicine	Reflections	2003
Academic Emergency Medicine	Resident Portfolio	2006

literal "Change of Shift." The medical trainee moves from the position of *person* to *physician*, changing clothing as she dons the white coat; changing character as he adopts a medical morality—or attempts to. What the editors of medical journals tacitly acknowledge by adding sections for physicians' personal writing is that by the end of the 20th century, physicians need space in the profession to share their feelings concerning their inability to be perfect, to give voice to the moral struggles that medicalization has created even for them.

Postgraduate Training and the Medical Imperative

Medicalization, the social movement powered by medicine's ever-increasing prominence in all aspects of life, presented Americans with new technological and pharmaceutical options to postpone death. To physicians set apart from the public, however, medicalization handed down an ultimatum: the medical imperative, demanding "the compulsive use of technology to maintain life" (Callahan, 2000, p. 654). Pressure was placed on physicians and trainees to extend life and not offer to patients the option of dying, because death was and is equated with failure. In the culture of medicine, trainees were, and still are, taught to transform the "miracles and the macabre" (Hafferty & Franks, 1994, p. 865) they encounter from "that which is startling, disquieting, and/or morally unsettling into something that is routine, acceptable, or perhaps even to be preferred" (p. 864). For interns and residents, this moral enculturation has become an exigence prompting social response; "a socially recognizable way to make his or her intentions known…an occasion, and thus a form, for making public our private versions of things" (Miller, 1984, p. 158). Medical journals' new sections--"courtyard[s] of

creativity," to quote the *JAMA* editor—provided just the occasion and just the form for trainees to respond to the many contentious aspects of enculturation. As noted earlier, *courtyard* is significant, for the word implies privilege: an enclosed space reserved for those with sovereign *authority*: physicians and trainees airing personal concerns about the moral practice of medicine, particularly in relation to death. So, too, is *creativity* notable, for it affords trainees the power to resist enculturation, particularly the distancing of death, through discursive invention.

Death Instruction During Residency

Death does not fit the educational paradigm used to train physicians in which residency is viewed as an "apprenticeship" that still relies upon the "'see one, do one, teach one' model" (Rodriguez-Paz et al., 2009, p. 244). This training model was developed by Sir William Osler, a Canadian physician who was one of the six founders of the Johns Hopkins University medical school in 1893. Even now, "the Osler mystique" (Ferngren, 2000, p. 825) prevails as educators frequently quote Osler in relation to medical humanism. His famous dictate that doctors "see one, do one, teach one," however, is decidedly reductionist and procedurally based. People die in as many different ways as they live: a point directly addressed by an attending physician in an article he wrote in response to a resident who criticized him for "Giving Up" (Cripe, 2009) on a patient. For the resident to "see one" dying patient for one day—a 16-year-old girl whom the physician-author had treated for 7 years—cannot be equated to checking off "see one" and "do one" on a list of clinical skills, much less does it qualify

the resident to teach how to manage the care of dying patients.[27]

While Osler's model of medical education is still honored, more formal requirements have been set for postgraduate training, although the focus remains on performing procedures. The American Council for Graduate Medical Education (ACGME), which oversees all allopathic[28] medical training in the United States, reviews, approves, and accredits programs that each medical specialty residency committee establishes for its trainees. All residents must meet competencies standards in six areas: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practices (ACGME, 2013a). Under "Patient Care and Procedural Skills" (ACGME, 2013b) is the requirement that residents "provide patient care that is compassionate, appropriate, and effective for the *treatment* of health problems and the *promotion* of health"; they must "competently *perform* all medical, diagnostic, and surgical *procedures essential* for the area of practice" (p. 8; italics added). In sum, residency training is heavily based on learning how to competently perform procedures that treat and/or promote health; procedures that trainees essentially "see" and "do" in order to someday "teach."

Death is not referenced, nor does the subject come up on a search of the ACGME website, except for information related to the specialty of hospice and palliative medicine. Indeed, for many medical specialties ranging from anesthesiology to urology,

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[27] See Fish and Cossart (2006), who depreciate the use of "tick boxes" to show trainees' achievement in medical education. "It fails to take account of the real character of professionalism on one hand, and the artistry of practice on the other hand, both of which attracted them to career in medicine in the first place" (p. 403).

[28] Academic medical centers employ both allopathic (M.D.) and osteopathic physicians (designated as D.O.). Osteopathic physicians practice primary care with an emphasis on "manipulative medicine" that "emphasizes helping each person achieve a high level of wellness by focusing on health promotion and disease prevention" (American Association of Colleges of Osteopathic Medicine). Accordingly, postgraduate requirements for D.O.s are different from M.D.s.

the care of dying patients may not be viewed as essential to their everyday practice. In primary care residencies, however, trainees do, and should expect to, confront dying patients; death is not merely a concern but an inevitable medical event. During a family medicine residency, trainees gain expertise in decision-making on their own, as with diagnoses, and with patients, particularly those at the end of life. When patients do not opt for medical interventions, trainees learn to shift from providing treatment to relieving pain and providing comfort (Schultz, 2003, p. 91). In one sense, the dying patient presents as "an imperfection marked by urgency; it is a defect, an obstacle, something waiting to be done" (1968, p. 6), to use Bitzer's definition of *exigence*. The physician is bound by professional oath, didactic education, and clinical training "to bring about the significant modification of the exigence" (p. 6); to provide medical care that will prolong life, or, if that is not possible, then attempt to alleviate patient suffering, identified as another key moment in medical practice (Jewell, 1999). In rhetorical terms, then, death and the suffering of dying patients are an *exigence* to which physicians must respond. When they perform procedures such as cardiopulmonary resuscitation and intubation, they are "doing something."

Yet, *exigence* also refers to how we make meaning of an event. "Exigence is a form of social knowledge—a mutual construing of objects, events, interests, and purposes that not only links them but also makes them what they are: an objectified social need" (Miller, 1968, p. 157). Residency is a time during which physicians-in-training must learn how death is construed in the culture of medicine; they must learn how to find "their comfort level" in handling the "social need" that dying patients present. In this sense, *exigence* is not "'an inventory of ongoing sights and sounds but a semiotic

structure'" (Halliday quoted by Miller, 1984, p. 157): a meaning illustrated in the article by physician-author Cripe referenced earlier in this section. As an attending physician, he is accused by a resident of giving up on a dying patient when Cripe does not offer her one more chemotherapy regimen. What he wants to tell the trainee is that learning *not* to do a procedure often is the most humane choice at the end of a patient's life, but arriving at such a reconception of medical care requires time. It also requires thoughtful consideration that challenges the medical imperative and the urgency surrounding it. As one medical educator says, residency is:

> a time of incredible internal turmoil. Where/how does a resident physician gain comfort with respecting wishes for no intervention? How does a caregiver well versed in modern techniques deal with an overwhelming sense of failure when there is no 'good medicine left'—or worse yet, when that physician believes that 'a simply surgical procedure' would ameliorate the problem and the patient has an altogether different opinion? (Schultz, 2003, p. 91)

In response to Schultz's questions above, I suggest that residents look to the personal writing about dying and death that their colleagues have published in medical journals. These texts represent new semiotic structures that can help trainees learn how to invent their own discursive responses to the exigence that dying patients and their deaths present. In other words, these texts provide a different perspective on dying and death; a rhetorical understanding.

The fact that more than 120 present and former physician-trainees, in addition to other physicians and medical students—the extent of the study corpus's authors--have chosen to write and publish articles in medical journals about their personal experiences with dying and dead patients attests to the problem that death presents in medical education. The traditional response--seeing one dying patient or dead body; doing, as in caring for, one terminally ill patient at the end of her life--does not fully address trainees'

ignorance about the end of life any more than exhibiting competency in observable skills and procedures proves an understanding of death at a conceptual level. Death presents a "danger," to use one of Miller's descriptive terms for *exigence*; it points to a physician's failure to sustain a patient's life. Thus, death can injure a physician by encouraging denial, which distances the person from their emotions, their personal response, whether it is guilt, shame, grief or unbearable sorrow. The danger, then, is the bifurcation of the individual physician who is separated from him- or herself.

When viewed through a rhetorical lens, however, the question--the danger death poses; the ignorance it presumes on the part of the resident; the separateness that it ascribes to trainees--can be opened up, allowing for new insight into the corpus and the corpse as viable subject matter.

Corpus Inventory

Table 4.3 shows an inventory of the journals in which the articles written during postgraduate clinical encounters with dying and/or dead patients appeared; the articles are arranged in chronological order of the journal's inaugural publication date for these types of personal articles. (For a listing of each individual text, see Appendix B.) The corpus consists of 126 articles published in 14 medical journals over a 45-year span.[29]

I begin by commenting on the significance of select characteristics listed in the inventory and why each is important to this dissertation: who is writing the articles in terms of themselves as authors; whether the texts are regarded as truthful accounts; and when physicians are writing the articles relevant to the time of the death described.

[29] All medical journals selected are printed in English with the exception of *Canadian Family Physician* and *Canadian Medical Association Journal*, which also publish in French.

Table 4.3: Corpus Inventory

Journal Title and Publisher	Number of Texts	Publication Date	Authors' Gender
BMJ British Medical Association	22	1968-present	12 males, 7 females, 2 names uncertain, 2 anonymous (1 identifies as female)
American Journal of Medicine Association of Professors of Medicine	5	1978-97; 2005-present	3males, 2 females
JAMA American Medical Association	18	1980-present	11males, 6 females, 1 anonymous
Journal of General Internal Medicine Society for General Internal Medicine	14	1986; 2007-present	9 males, 5 females
Annals of Internal Medicine American College of Physicians	14	1991-present	10 males, 6 females
nnals of Emergency Medicine American College of Emergency Physicians	11	1993-present	10 males, 1 female
CMAJ Canadian Medical Association	3	1998, 2005-2006	1 male, 2 females
Journal of Palliative Medicine Center to Advance Palliative Care	6	1998-present	3 males, 3 females
Family Medicine Society of Teachers of Family Medicine	4	1998-present	2 males, 2 females
Health Affairs Project HOPE	4	1999-present	3 males, 1 female
Canadian Family Physician College of Family Physicians of Canada	6	1999-present	4 males, 2 females
New England Journal of Medicine Massachusetts Medical Society	8	2002; 2004-present	6 males, 2 females
Annals of Family Medicine 6 Family Medicine Associations	1	2003-present	1 male
Academic Emergency Medicine Society for Academic Emergency Medicine	9	2006-present	4 males, 4 females (1 repeat author)
SUMMARY	126 Total texts	Published over 45 years	78 male authors, 42 females, 2 uncertain, 3 anonymous

These results correlate to an epistemological assumption of my dissertation: that physicians have experienced and have written about experiences that I refer to as clinical encounters "near death" during their internship, residency, and fellowship years. The results also are important for the in-depth analyses of physicians' personal writing at the levels of text and discourse in the chapters that follow.

Gender

From the Corpus Inventory shown above in Table 4.3, the gender of physician-authors can be summarized as: 78 males, 42 females, 2 named authors whose gender is uncertain,[30] and 3 anonymous authors. Thus, 63% of the texts were authored by males compared with 34% by females. The reason for the higher number of male physician-authors in the study corpus may be accounted for by the traditionally higher number of males who have graduated from medical school in the United States over the past 45 years. The Association of American Medical Colleges (AAMC) reports that in 1970-71, 90.8% of the total medical degrees awarded went to males and 9.2% to females.[31] In 1980-81, the percentages shifted to 75.1 males and 24.9 females: a trend that continued over the next 2 decades. In 1990-91, the percentage of male graduates was 64 and females, 36; in 2000-01, 56.8% males and 43.2 females. To date, the largest percentage

[30] Robin Carmichael and Rubeta Matin signed their articles that were published in *BMJ***.** However, their first names can be used by either gender; a Google search did not produce photographs to confirm the physicians' gender.

[31] In addition to physicians with M.D. degrees, physician-authors in the corpus include osteopathic physicians (designated as D.O.) who practice primary care with an emphasis on "manipulative medicine" that "emphasizes helping each person achieve a high level of wellness by focusing on health promotion and disease prevention" (American Association of Colleges of Osteopathic Medicine). Academic medical centers employ both osteopathic and allopathic (M.D.) physicians.

of women to graduate from U.S. medical schools was 49.3% in 2007-08 (AAMC).[32] In the most recent statistics reported, 2011-12, the percentage dropped slightly to 47.8% women of total medical graduates.

Anonymity and Personal Writing

Another significant result in the inventory is the number of anonymous physician-authors: 3 of the 126 total number of authors, or 2.4%. The fact that more than 97% of the physicians chose to publicly claim authorship suggests that they are willing not only to own their experiences in the face of possible criticism from their peers, and potentially the public; equally important, they will vouch for the truthfulness of their accounts, all of which will be significant when discussing the oppositional nature of the articles in Chapters 6 and 7.

Two of the anonymous texts were published in *BMJ*. The author of "Terminal Careless" (1989), who strongly criticizes her dying father's medical care, identifies herself only as the patient's "doctor daughter" (p. 1471). The author of "Beyond Breaking Point" (2001) describes him/herself as a "'bloody overdose'"; a "parasuicide" (p. 1137) or individual who attempted to commit suicide. These physicians' anonymity is understandable: to publish either article under the physician's real name could be detrimental to their professional standing in the medical community. The third anonymous text raises the question of an author's truthfulness, which I address next.

[32] Though it is beyond the scope of this study, a future research project could investigate the number and chronological distribution of female physicians writing about clinical encounters in medical journals compared to their male counterparts.

Authenticity of Personal Writing

Among the most controversial articles published in *JAMA* is "It's Over, Debbie" (1988), attributed to "Name Withheld by Request." The author identifies him/herself in the second sentence only as "a gynecology resident" (p. 272). The article, which recounts an "apparent act of mercy killing" (Lundberg, 1988 April 8, p. 2141) elicited more than 150 letters to the editor in the first 3 months after publication. George D. Lundberg, M.D., *JAMA* editor at the time, responded specifically to readers' questions of truthfulness in an editorial: "As we do with authors of all articles and essay we receive, we trusted the author of 'It's Over, Debbie' to be telling the truth, and we made no independent investigation of the facts" (p. 2142). Lundberg devotes two paragraphs to explaining the editorial board's decision--which was not unanimous--to publish the essay according to the author's "proviso" that it be printed anonymous. He concludes by stating, "We believe that the greater public good would be served by publishing the essay to stimulate debate [about euthanasia] rather than by investigating a purported act of one physician" (p. 2142).[33] This comment, in addition to points in the editorial, provides insight into the purposes physicians' personal texts serve on a genre level in medical

[33] The authenticity of the events recounted in two other texts in the corpus also could be questioned: "Innocent Bystander" and "Art and the Science of Medicine," each published in a 1995 issue of *Annals of Internal Medicine* and both attributed to Michael A. LaCombe. The first text is written in the form of a script for three characters--an intern, senior resident, and nurse--treating a woman who dies in the emergency room after a medical mistake is made. The second text is written in first person from the point of view of a trainee who, after shadowing a clinical oncologist, "Art," choses to become an academic oncologist researcher pursuing "science." LaCombe, however, is identified as an internist practicing in rural Norway, ME, which seems to challenge the narrator's veracity. In the inaugural personal essay published in *Annals*, LaCombe refers to experiences with his patients as "'case histories'" (1990, p. 891) and urges future physician-contributors to become "a part of the stories in which we may play many roles." I suggest that his use of quotations marks be understood as a code gloss, which allows him as a physician-author to blur the lines between actual case histories of and stories about patients. Stories, he writes, are "about that moment of sharing…when nothing else matters" (p. 891): a line of reasoning that seems analogous to Lundberg's claim that the need for public debate trumps the veracity of one physician's narrative.

journals, which will be discussed in Chapter 7.

When Private Voices Become Public

I draw attention to two findings in the Corpus Inventory that are related to the timing of the publication and the writing of physicians' articles. First, I comment on the dates of journal expansion, which reveal the time period represented by the study corpus as a limited historical time. Second, I discuss the range of time between a clinical encounter and its telling represented in the corpus, because the differences in time support my argument in later chapters that physicians' personal writing functions as more than catharsis; it serves an important rhetorical function in the culture of medicine.

Years of Journal Expansion

According to the Corpus Inventory, the expansion of general medical journals to accommodate physicians' personal accounts of their professional experiences is limited to a particular time in history, from 1968-2006. When and why the first four medical journals opted from 1968 through 1991 to expand has been discussed earlier in this chapter. Yet, it should be noted that exactly half of the medical journals that comprise the study corpus—seven journals--added sections for physicians' personal writing during the 1990s, as shown in Table 4.3. Their introduction coincides with identification of the "hidden curriculum." Although the article was published in 1994, the research would predate publication. In fact, five of the seven journals added sections in the last 3 years of the decade, thus appearing after Hafferty and Franks' seminal article.

In the final decade of the corpus—2000-2013—three medical journals added sections for physicians' personal writing. Included is *The New England Journal of Medicine*, which has the highest impact factor of any medical journal. "Perspectives," introduced in 2002, is described on the journal's online "Author's Center" as "short, thoughtful essays from well-known experts on issues affect both the medical community and society at large." It should be noted that *The New England Journal of Medicine* has sought "opinion pieces" from physicians since 1973 in the well-known section, "Sounding Board."[34] In his 1985 editorial entitled "The Journal as an Open Forum," physician-editor Arnold S. Remen justified the inclusion of opinion articles, noting that "[i]t is no longer sufficient for [physicians] to be dedicated, technically proficient, and up to date. We must also be aware of the new and economic forces that are impinging on medicine…a new consensus about our profession and its role in society is in the making" (1985, p. 1385). When the journal added "Perspectives," however, the new editor did not introduce the section, define its purpose, or reference Remen's earlier editorial, which is notable since the journal was a "late adoptor" of the new genre.

In my search, I could not find mention of any general medical journal adding a section for physicians' personal writing after 2006. This finding and the fact that only three journals expanded in the first decade of the 21st century may be related in part to the growth of blogging, which has been described by rhetorical scholars as "the peculiar intersection of the public and private" (Miller & Shepherd, 2010).[35] Since their study,

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[34] *The New England Journal of Medicine* published a controversial opinion piece in "Sounding Board" by physician Timothy Quill who admitted to helping a patient die. Thirteen years later, he published a follow-up article on end-of-life care in "Perspective" (see Quill, 1991 and Quill, 2004). It did not meet the criteria for the study corpus, however. Both articles are frequently discussed in medical ethics.

[35] A recent study compared personal reflections by medical students about their clerkships in two forms, written reflections and blogs, and found no significant difference in themes addressed or depth of reflection (Fischer, Haley, Saarinen, & Chretien, 2011).

social media has expanded to include social sharing through applications or "apps" such as "Whisper' and "Secret" (Eaton, 2014). Also, an increasing number of journals publish online in part or exclusively. *The Journal of General Internal Medicine* announced in spring 2013 a new section for personal writing by residents, "This Living Hand," which appears only on the journal's website.

Personal Writing as an "Other Type of Article"

Since an increasing number of medical journals regularly feature physicians' personal writing, *The AMA Manual of Style*, the standard reference guide in medical writing, includes the discourse as one of the eight types of articles published. The articles are listed in order of their perceived significance: reports of original data, review articles, descriptive articles, consensus statements and clinical practice guidelines, opinion articles, correspondence, and book reviews. The final category is "Other Types of Articles," described as "other items and articles that do not fit into any of the major categories. Examples include personal reflections and essays (e.g., A Piece of My Mind in *JAMA*)…" (2007, p. 5). In Chapter 7, I argue that *Perspective Writing* qualifies as another "major" type of medical writing and should be recognized as another genre of medical literature, for it meets many of the same criteria by which the seven other genres are judged: *perspective writing* is original; benefits patients; guides clinical decisions; makes novel observations; and provides useful information.

Some Caveats About the Corpus

In the study corpus, the time from the clinical encounter with death to the appearance of a published account ranges from more than a half-century to the next academic year. In "My First Case" (Davies, 2004), a retired British consultant (equivalent to a U.S. attending physician) recalls being paged as an intern to confirm the death of a young barmaid in February 1940, an event that occurred 64 years prior. The author of "Requiem for Mr Bojangles" (Chan, 2002), identified as "a second-year family medicine resident at the University of Alberta in Edmonton" (p. 122), writes about a dying patient he was assigned the previous year as a 1st-year trainee.[36]

Whether they choose to delay their response or to write soon after, the differences in time attest to the prevailing impact, psychologically, cognitively and physically, of near-death experiences that reverberate throughout physicians' careers, a claim I will return to in Chapter 7. For example, as the editor of "Lessons from Out Learners" in *Family* Medicine notes in introducing that section, "It is not important if it was something that happened yesterday or some time ago. Through our shared experiences, we might all learn to become better teachers and learners" (Grant, 1998, p. 257). Texts in the corpus recount experiences from the authors' postgraduate years, which vary. The Accreditation Council on Graduate Medical Education (ACGME) considers "residents" to encompass interns, residents, and fellows (ACGME glossary). The accreditation body and physicians alike refer to trainees in their 3rd or final year as "chief residents" or

[36] Chan's article appears in *Canadian Family Physician's* section, "Residents' page." *Academic Emergency Medicine* and *Annals of Emergency Medicine* also feature sections written by and for residents in which the time span between events and their recounting is relatively short.

sometimes as "senior residents."[37]

In addition to resident physicians, I found many personal texts written by practicing physicians, as well as several by medical students, about their clinical encounters with death. (Resident physicians are not the only medical professionals to write about experiences with dying patients.) I have included five of these accounts in my corpus, because they serve as triangulation in a doubled sense: 1) the texts provide another perspective on events in which residents are central figures and 2) they also complicate the notion of *when* physicians choose to write. Reflections by medical students that I have included heighten the sense of urgency that characterizes the real-time practice of medicine, while those by attending physicians illustrate how time also can impede medical training, silencing not only those teaching residents and, by extension, trainees, but even more important, the very subject matter.

Medical Student Authors

Included in the study corpus is "First Death" (Bartlett & Mukhtar, 2009), in which two 2nd-year medical students write about the first time they observe in an emergency department where they witness the death of a boy after an all-terrain-vehicle accident. Their reflections were published in *Academic Emergency Medicine* in "Resident Portfolio," a section where postgraduate trainees write "self-reflections" about recent clinical encounters and faculty members write commentaries that emphasize "'learning points'" to be gleaned from the article. The students' perspectives were included,

[37] The British medical system uses different titles from those in the United States to distinguish trainees at particular stages of training. "Junior doctor," "house officer," and "registrar" are equivalent to a U.S. resident; a "senior registrar" is comparable to a fellow (Roberts, 1991).

according to the editor, because they "provide several poignant lessons to the emergency medicine resident"; in particular, residents "need to, at some point, deal with the emotional components of the experience" so they do not forget "this basic humanistic reaction" (Chisholm, 2007, p. 827). A section commentator adds: "Unencumbered…with clinical thoughts of the need to act, [the students] had time to reflect on death and dying the ED" (Iserson, 2007, p. 826). In the students' words, the physicians were the ones "redonning their gowns, gloves, and masks" amid the "panic and frantic action" (Bartlett, 2007, p. 825) to resuscitate the 13-year-old boy whose "chest was cracked open, and his heart suddenly lay in the hands of the physician who relentlessly pumped his heart manually" (Mukhtar, 2007, p. 826) with a "look of desperation and determination" (Bartlett, 2007, p. 825). In contrast, the student-spectators could take time to register their multiple and conflicting emotions--"excited, yet truly saddened; calm, yet anxious; and hopeful, but truly wary of a poor outcome" (Mukhtar, 2007, p. 826)—which was not afforded to the physicians. Furthermore, witnessing or participating in events that result in a patient's death can mean involve drawing upon more than medical acumen to process its meaning. As one student notes, "I even thought about my own death" (p. 826).

Attending Physician Authors

Three articles written by attending physicians are included in the corpus, because they describe how trainees the authors supervised responded to the deaths of patients. More importantly, the physicians acknowledge that they write years after the events

occurred because, at the time, they had remained silent: further evidence of how medicine denies death.

In "Going Fishing" (Day Adams, 1996), the physician-author said she lacked the language to explain to a trainee how she could support a patient's decision to forego treatment to return home to do what he enjoyed most, fishing. The attending at the University of Connecticut recalls how "[m]y student and I did not speak then—the early 1970s—of beneficence, nonmaleficence, autonomy, and justice….We did not use this vocabulary of bioethics, because the discipline was just being developed and was not part of our education as physicians" (p. 475). Whether *autonomy* or *justice* actually encourages a trainee to acknowledge the power of death or understand medical futility can be disputed, since the abstract terms could arguably be said to emotionally distance a physician and foreclose the possibility of empathy.

In another article in the corpus authored by an attending, the physician has access to language but not time. In "Giving Up," referenced earlier in this chapter, physician Larry D. Cripe describes how a senior resident stopped him in the hall outside the dying patient's room, demanding to know why the attending was not offering more treatment. Cripe remembers "the resident's bruised expression…the sagging shoulders and distracted shuffling of [the] intern…my grief that Dawn's life was drawing to a close" (2009, p. 1747). "I had wanted to respond, 'Spend time with me and see what I see.' But how much time would the resident have to spend with me? A month? A year? A decade or two? Would she ever see what I see…?" (p. 1747). Time may compel some practitioners to *not* respond to death with the same urgency it impels trainees to respond to emergencies, because they have a more complicated understanding of time. Yet, the

attending's silence also may result from the paradoxical nature of the subject he was (not) addressing, which medicalization and the hidden curriculum likewise do not address. Death is what medical professionals work to prevent; it is also an inevitable medical outcome.

Conclusions

By using a rhetorical lens to analyze data gathered during the collection of the study corpus, my intention has been to recognize aspects of physicians' personal writing published in medical journals and the regular sections medical journals added to accommodate this new discourse. I argue that a rhetorical approach presents medical discourse in a context of social, political, and cultural events as a unique and as yet unidentified rhetorical situation, which contributes to a broader understanding of medicalization and its force upon society in general, and dying and death in particular. A rhetorical approach also illuminates this period of time as a unique historical period in medicine and, in a similar way, links physicians' discourse to the hidden curriculum, which has not previously been done. At the same time that a rhetorical analysis situates medical discourse as a response to the hidden curriculum where it might be assumed to function as a tool of moral enculturation, the analysis affords a more nuanced understanding of how the profession of medicine, as represented by journal editors, use the tools of enculturation to subvert that very process by soliciting discourse that resists the culture of medicine's conventions. As a result, a rhetorical investigation of physicians' personal discourse at the corpus level reveals how individual representatives of the profession challenge the fundamental assumption that medicine is foremost a

scientific practice. In fact, the solicitation and publishing of physicians' personal articles about their professional experiences attests to the growing recognition that, since the latter half of the 20th century, the practice of medicine has been strongly influenced by society and culture. Scientific knowledge alone is insufficient for training of physicians. It divides physicians into bodies proficient at performing procedures, and minds set apart from the person; a bifurcation that brings about moral dis-ease. While identification of mind-body dualism is hardly new—Cartesian thinking has dominated the practice of medicine for more than 200 years—it has not previously been related to physicians' personal discourse and the rhetorical role that writing plays in the profession. In other words, a rhetorical understanding of physicians' personal writing discloses how discourse allows for the recomposition of physicians' identities as persons essentially the same as the patients to whom they attend; persons who are not, and cannot be, set apart from death, much less separated from their private emotional responses to unsettling experiences.

Thus, results from the collection and analysis of the study corpus provide compelling evidence that physicians have experienced and subsequently written about experiences during their internship, residency, and fellowship years with dying patients; in fact, their encounters with death present an exigence that calls for response as social action. Physicians-in-training cannot depend upon medical procedures when providing care at the end-of-life. Rather, they must learn how death is construed in the culture of medicine, for the care of dying patients can be emotionally overwhelming and existentially challenging, and often requires physicians to draw upon not only medical expertise but their own humanity.

The ramifications of understanding physicians' personal discourse through a rhetorical lens, then, extend beyond medical education and medical practice. Their discursive responses to the exigencies of medical practice, particularly death, constitute social actions, which impacts how physicians relate to others as well as to their own selves; how they resist the culture of medicine through creative reinvention; and how they challenge the power of the hidden curriculum that extends into their personal lives; all of which will be investigated in the remainder of the dissertation. In the next chapter, I discuss results from the discourse analysis of each article in the study corpus, which further substantiates the rhetoricality of the texts, and ultimately, a new genre and sub-genre.

CHAPTER 5

DISCOURSE ANALYSIS: DISMEMBERING THE CORPUS

Introduction

Findings from the discourse analyses of individual texts that comprise the study corpus reveal how physician-authors rhetorically resist the conventions of medical discourse thereby challenging the effects of medicalized death: the depersonalization of physicians and dying patients, and the resulting dehumanization of each. Physician-writers claim personal agency by employing active voice rather than the passive voice used traditionally in medical and scientific writing. They write in first person, affording their texts subjectivity and a uniquely personal point of view, rhetorical strategies that oppose the "conventional impersonality" (Segal, 1993, p. 525) of the grammatical third person and the impartiality that ensures the objective reporting of data that can be universally observed. Instead, physician-writers draw attention to their own authority by strategically using repetition, metadiscourse, and emotive language to describe their professional experiences from personal and partial perspectives. They use figurative language that not only undermines editorial maxims calling for medical writing that is clear and direct; metaphors and euphemisms problematize principles of patient care, requiring re-examination rather than allowing for replication, a foundation of medicine as an applied science. I argue that these six rhetorical tools or discoursal features of

physicians' personal writing serve as "rich" (Barton 2002) features, which distinguish this personal discourse from other types of medical writing and support my proposal to recognize physicians' personal writing as a distinct genre of medical discourse.

By identifying rhetorical strategies, we also can discern how physician-trainees contest prominent values in the culture of medicine. Thus, these discoursal findings respond to my second research question:

RQ#2: *What does the genre knowledge articulated by necrography tell us theoretically about medical practitioners' behaviors and attitudes toward death?*

Specifically, physician-trainees resist the cultural perception that dying patients are not "real" individual persons. Interns, residents, and fellows challenge medicine as an abstract practice in which physicians treat patients as problems to solve with algorithms, common scripts and procedures provided by the institution. For physicians-in-training, death has not yet become a medicalized event, which they can or should prevent at all costs. Therefore, many cannot avoid the emotional toll when attending to dying patients by detaching and distancing themselves. Their experiences caring for patients prove that they cannot, and more importantly, do not want to, become different people as physicians: professionals who divide their rational selves from their corporeal, affective selves. Trainees realize through their interactions with dying patients how they, too, experience all facets of life, including their professional practice, through their bodies. To not do so only brings about moral distress; the conflict between personal and professional when trainees find themselves identifying with the human suffering of patients. Thus, physician-trainees resist the hidden curriculum's notion of morality and

limited conceptions of what are appropriate professional ways of being a physician who is assigned to care for dying patients.

In this chapter, I elaborate upon these findings, identifying and discussing specific rhetorical strategies physician-authors use to challenge, resist, and undermine medicine's cultural attitudes, values, and behaviors when writing about their personal experiences with nearly dead and newly dead patients. I give examples of five strategies or rich discoursal features identified in the study corpus-- repetition, metadiscourse, emotive language, euphemisms, and metaphors—and then discuss how these reveal tacit assumptions and values in medicine. Narrative, the predominant rich feature, will be discussed separately in Chapter 6. Figure 6.1 is a schema of rich features in the order they will be discussed in this chapter.

Rich Features That Personalize Physician-Authors

Repetition

Physician-authors use repetition to transgress medicalization's demarcations between dying patient and physician, body and mind. They recognize patients at the end of life as individuals, which means trainees question the effectiveness of communication scripts and procedures that require them to treat all patients the same. To comprehend dying patients as real persons, trainees rely upon sensory knowledge from their own bodies, which contradicts the abstract, rational thinking endorsed by medicalization. As a result, physician-trainees rehumanize themselves as they recognize the humanity of the dying, thereby undermining medicine's morality. They do so rhetorically by using repetition in three ways: to intensify emotions; to increase comprehension on multiple

1. *REPETITION*
    - Intensification
    - Comprehension
    - Coherence

2. *METADISCOURSE*
    - Code Gloss
        - *Dashes*
        - *Quotation marks*
        - *Capitalization*
        - *Italics*
    - Validity Markers
        - *Emphatics*
        - *Hedges*
        - *Attributors*
        - *Attitude markers*
        - *Commentary*

3. *EMOTIVE LANGUAGE*
    - Politically incorrect feelings
    - Personal inadequacy and insecurity
    - Detachment and distancing
    - Public displays of emotion

4. *EUPHEMISMS*

5. *METAPHORS*
    - Descriptive words and phrases
    - Recurring metaphors
    - Article titles

Figure 6.1 Rich Discoursal Figures

levels; and to create structural and emotional coherence in the text and in their own person.

Intensification of Emotions

Articles by physician-authors show a patterned use of statements, phrases, and words that problematize assumptions, ideas, and situations related to death in direct opposition to medical and scientific convention. Definite statements, a prominent rich feature of medical discourse (Barton, 2002), present the research process and findings as "nonproblematic" (p. 31). Definite statements are straightforward in their meaning, drawing attention to the research process as opposed to the researcher; they "represent an idealization of research processes" (Barton, 2002, p. 33), persuading readers "of the validity of the medical model" (Segal, 1993, p. 528) through the impersonalization of the researcher. In contrast, physician-authors use repetition to oppose the medical model for the way it dehumanizes dying patients and providers alike.

- In "Refilling Empathy," the resident-author challenges the medical model of the doctor-patient conversation that failed to adequately prepare her for the reality of practice. She repeats *real* to emphasize the disconnection she experiences between what she had to learn for her recent board exams and what she actually says to patients. "I dutifully memorized the statement suggested in *First Aid for the USMLE Step 2 CS* study guide: 'This must be difficult for you,' 'I'm sorry you have so much pain,' etc." "Now I was back in the *real* world with *real* patients, *real* problems, and *real* consequences of communication" (Chang, 2012, p. 615; italics added).

- The trainee-author of "What Would I Want If This Were My Father?" explicitly criticizes the culture of medicine for a faulty system that results in inadequate care of patients at the end of life. As a result, he second guesses his decision as a senior resident to trust others' decisions about a patient for whom he was responsible and who eventually dies. "*I wish we had* transferred J.L. to the ICU…*I wish I had* communicated more clearly to the intern…*I wish I had* been quicker to recognize [the patient's] confusion…" (Gopal, 2006, p. 1121; italics added). Here, anaphora—the repetition of the phrase *I wish I had* at the beginning of each sentence—underscores the depth of the trainee's personal regret.
- An internal medicine resident repeats the word *smell*, increasing readers' visceral as well as emotional reactions to the patient until there is no doubt as to the intensity of each. The resident begins by describing a new patient, Mr. Watson, who "had had sepsis from infected, necrotic skin lesions" that had a distinctive smell, which the nurse bluntly identified: "That's the stench of death" (2006, p. 328). Over the course of the next week, the resident realizes that

  > …his *smell* had somehow made its way into my apartment, into my bathroom when I showered, into my kitchen as I made dinner, into my living room and bedroom. His *smell* was in my car the next morning as I drove to the hospital. I *smelled* his dying skin on all my patients, on all the new patients I admitted, and I didn't stop *smelling* Mr. Watson until three in the morning the following day, when I was paged out of my in the call room to declare him dead. (p. 328; italics added)

  Unable to physically distance his body from that of the dying patient, the resident is coerced through his own sensuality into recognizing the person of

the patient as well as his own. Thus, repetition personalizes the bodies of each as the smell of one infuses the being of the other. The rhetorical strategy counters the detachment and depersonalization especially at the end of life that is endorsed by the hidden curriculum.

Comprehension

Physician-authors employ anaphora to exhort readers to *listen* so as to comprehend, to take into their lives what they are saying about dying and death[38] as a human experience that connects all people regardless of economic status or profession. Thus, physician-authors complicate the meaning of *comprehend* by alluding to the word's shared meaning with *comprehensive*; rhetorical strategies that challenge scientific precision.

- A fellow writes about caring for a 16-year-old Kenyan girl who, like both of her parents, was HIV positive and is now dead: "*I paid* the bribe to the hospital administrator to get her body released from the morgue. *I paid* for the cheap wooden coffin and matatu bus so that she could go back to her village for burial, strapped to its roof in her pink dress. *I paid to* understand that HIV in Africa isn't an economic or resource argument, nor is it about population control or failed prevention models" (Murray, 2005, p. 1510; italics added). Repetition foregrounds how international medical care for dying patients, or the lack of, involves the physician personally and financially, thereby redefining medical practices in personal terms.

[38] Repetition here also serves as a metadiscursive strategy (Johnstone, 2008) through which "speakers can situate themselves outside their words" (p. 165) and direct readers to their intended meaning.

- The anonymous author of "Terminal Careless" uses repetition to point out numerous sources of inadequate care of dying patients in a developed country. She criticizes the institution of medicine and the ways in which patient care was (not) delivered.

> My father was *failed* in his terminal care. I, his doctor daughter, *failed* to claim adequate care and analgesia for him…The general practitioner also *failed*…he *failed* even to consider that the symptoms might be genuine. And later he *failed* to give a man with definite disseminated carcinomatosis adequate and appropriate analgesia. Finally, the hospital *failed*…it lacked a system to ensure its proper administration. (p. 1471; italics added)

In these two excerpts, repetition connects patient, physician, hospital, and society, suggesting that the concept of health, as well as its delivery, encompasses all; health is comprehensive, which these trainees now comprehend. Repetition thus blurs boundaries, revealing the harmful effects of medicalization as a social force especially in situations related to death.

Coherence

On one level, repetition structures texts by creating coherence as repeated words and phrases link paragraphs. On another, it serves as a rhetorical tool allowing physician-trainees to reconstruct themselves as individuals, reincorporating personal emotions that death generates into their professional being.

- The resident who writes of a failed resuscitation of a boy in "When a Heart Stops" repeats the word *patients*, which has the effect visually and aurally of trying her patience; her ability to exhibit equanimity in the face of death. "After I saw a few patients…"; "I saw more patients."; "More patients."; "I

saw more patients."; "There were more patients to see."; "Another patient was placed in a room." (Kasman, 1994, p. 433). While repetition creates textual coherence by connecting seven consecutive paragraphs, it also conveys the emotional toll the resident paid when the boy died. "As I write this now my eyes fill with tears…tears I could not release then. There were more patients to see" (p. 433). Thus, she uses repetition to counter the medical maxim that physicians strive always for equanimity (Ofri, 2013, p. 147), a goal that causes her moral distress years after, for death *is* disturbing.

- A hematology-oncology fellow begins "Princess Abra" (Moorehead, 2008) like a fairy tale, a rhetorical form that itself counters medical conventions: "Once upon a time, Abra and I met in the emergency room" (p. 80).[39] Each paragraph recounts the progression of Abra's cancer and is followed by an anaphoric line, creating a parallel narrative of the physician's emotional reconstruction during the patient's dying process (emphasis added to excerpted lines below).

  This is the kind of child who gets cancer.
  This is what happens to a child who gets cancer
  This is what happens to you in the hospital.
  This is when you see that she's going to die.
  This is seeing that you love this kid.
  This is a lie.
  This is feeling helpless.
  This is slowly saying goodbye.
  This is how you view the end.
  This is when you stop being her doctor.
  This is too much for you to bear.
  This is when you hope for ever after.

  Not only does *this is* function as anaphora; the expletive stresses the

[39] I discuss in more detail the rhetorical form of "Princess Abra" in Appendix D.

information in the latter half of the sentence—the physician's grieving--as opposed to the conventional alignment of the most important information with the subject and verb. In addition, the use of second person enjoins readers to experience the affective journey with the physician. The result is a layered coherence: an integration of emotions of author and readers, from which logically and naturally follows a bodily integration, for emotions require corporeal awareness, all of which transgresses tenets of medicalization.

Metadiscourse

Physician-authors use metadiscourse to reinstitute the "self" into medical discourse as an embodied, cognitive subjectivity. My findings show that at the same time that trainees claim personal agency in direct opposition to medical convention, they redefine agency in nonmedicalized terms, which follows logically from their recognition of dying patients as real, individual human beings. Physician-trainees view agency as personal empowerment, not only the ability to take action professionally, which enables them to acknowledge their limited ability to control death. Instead, trainees' discourse shows respect for the ways death can disable physicians emotionally and professionally, which further suggests a subversive attitude in the culture of medicine: death as negation of the medical imperative and its assumed truth.

Below, I discuss the extensive use of metadiscourse through which physician-authors intrude into the text, instructing readers on *how* and *what* the discourse means. Writing in first person and using active voice, physician-authors resist the objectivity of traditional medical discourse and the taken-for-granted assumption that medical science

is self-evident. I focus on two types of metadiscourse--code glosses and validity—that each include subcategories. Code glosses encompass the use of dashes, quotation marks, capitalization, and italics, which visually set off selected words in the text. Validity markers tell readers how the authors view what they have written. These explanations or asides as to what the author is thinking/doing/saying at the time she is writing include emphatics, hedges, attributors, attitude markers, and commentary. I will give examples of each of the subcategories.

Code Glosses

Dashes

While dashes can indicate that information set off is subordinate or parenthetical to the rest of the sentence (Crews, 1980), dashes function in the study corpus as intentional interruptions. Physician-authors insert personal comments on situations and circumstances institutionally imposed upon them. Thus, dashes empower the trainees and authorize their voices.[40]

- The physician-author of a "Personal View" article in *BMJ* uses dashes to define himself by literally setting his identity apart from outside social forces that shaped his childhood self . "It began in 1960, and I think, I've just put most of the major bits of the puzzle—me—together" (Gregory, 1983, p. 757). He attributes his difficulty fulfilling the role of physician who cares about patients to his stunted emotional growth, beginning with the death of his

[40] The *AMA Manual of Style* defines dashes as a "form of internal punctuation [to] convey a particular meaning or emphasize and clarify a certain section of material within a sentence" (Iverson et al., 2007, p. 352). Dashes are likened to an "aside" and are to be used "sparingly."

father whom he was not allowed to mourn and "boarding school from 6 to 19, where bad feelings were beaten out of me—or rather into me." The author uses a dash the second time to correct the narrative society constructed for him; he emphasizes, rather than subordinates, information appearing after the dash.

- The physician-author of "The Demise of the Physical Exam" (Jauhar, 2006) uses dashes to interrupt the text so as to bring another, previously silenced voice into the conversation: "We residents were apt to regard the physical exam as an arcane curiosity—after all, who had the time to concentrate on proper technique when you had to round on 15 patients?" (p. 549). "But there were a few physicians—old souls? lost souls?—who proselytized on behalf of physical diagnosis, ascribing to it an almost mystical power" (p. 549). Dashes set off the collective voice of trainees, silenced at the bottom of medicine's hierarchy. In the first excerpt, the trainee questions teachings of the institution of medicine. In the second, he interrupts to bring into the medical conversation transgressive discourse: the repeated reference to attendings as "souls," a term unheard in academic practice but relevant to many people at the end of life.

Quotation Marks

The *AMA Manual of* Style cautions that quotation marks used as a "special effect," as "apologetic" (Iverson, 2007, p. 360), are usually "unnecessary." However, many physician-authors in the study corpus intentionally use quotation marks to criticize

how medicine sets its own terms related to death. The trainees call out cultural traditions, not in the low voice of an aside but in a defiant tone.

- In an article discussing new limits on residents' work hours, a physician explains: "'Every-other-night' meant arriving for rounds at 7 a.m.; working through the day, night, and most of the next day; going home to eat and sleep; then returning the following morning to do it all over again" (Gaufberg, 2008, p. 846). She and fellow residents preferred caring for ICU patients "every-other-night," because: "They were typically too short of breath to tell you long-winded stories in response to a simple yes/no question, and in any case all the 'important' data were right there at the bedside, beeping from monitors and nearly packed on nursing flow charts" (p. 846). Quotation marks also allow the resident to add an inflection of cynicism toward the medical care of the critically ill.
- The resident-author of "Should Natural Death Be a 'Billable' ICD-9 Code?" describes how his attending responded to his care of a DNAR (Do Not Attempt Resuscitation) patient. "On turnover rounds, the team went past the gentleman with a cursory, 'admitted, DNAR, nothing to do' report. When a stony faced, 'no-nonsense' attending physician made a side remark of, 'you have wasted too much time on this already DNAR patient,' it really struck me! (Lamba, 2008, p. 285). Through quotation marks, the trainee counters the cynicism of the attending and defies the hidden curriculum represented by the attending. He uses his rhetorical authority to problematize the tenet, "resuscitation is the most important goal" (p. 285), by asking: "Why is it then

> that we as physicians are still uncomfortable when faced with a naturally dying patient? Is it our inherent fear of dying or our immersion in our 'death-defying culture' that forms our attitudes and decisions? ...Would an ICD-9 code [that would permit physicians to bill for their time] for 'allow natural death' make us active participants in end-of-life care?" (p. 285).

Capitalization

A capital letter denotes power; it indicates a proper noun, rank or title. When used as a code gloss, capitalization shows how medical trainees discursively wield power against the medicalization of death. In the excerpt below, the trainee bestows power to Nature when he cannot reverse death and, conversely, empowers himself when he acknowledges the limits of natural life in contradiction to the medical imperative. He thereby absolves himself of responsibility and guilt imposed upon him by the culture of medicine when patients die.

- The pediatric resident-author of "What Is Natural?" interrogates the conflict of nature versus Nature that he confronts in his practice. He uses capitalization to personify forces in clinical situations where he has little impact: "Nature kills babies every day. I will never forgive Nature for the things I have seen it do to children" (Mendelsohn, 2013, p. 1784). Yet, the different definitions parents attribute to "natural" in relation to death complicate his understanding. One couple is upset when their home-birthed baby ends up in the hospital ICU "covered in wires and being filled with intravenous fluids and antibiotics in a sterile hospital. This was

> *not natural*" (p. 1783; emphasis added). The mother of a newborn diagnosed with a fatal syndrome would not consider "allowing this child to die naturally." How the trainee resolves his dilemma is evident through his revised use of capitalization: "I am discovering that an unspoken facet of my training is to understand what is natural, when it is time to fight Nature to the end, and when it is time to yield to its wishes…at the end of this road is the appreciation that death is inevitable, unavoidable, and wholly natural for everyone, from the elderly to the newborn. Cruel, but natural" (p. 1784).

Italics

Italics, used to emphasize words or phrases, are found throughout the study corpus often in conjunction with other forms of code gloss. Thus, physician-authors use italics to underscore their metadiscourse, to amplify their personal voices when speaking of death and to actively contest medical convention by claiming personal agency, even when it means they cannot act to prevent death.

- The physician-author of "Caring for Patients" uses italics to distinguish the positive elements of patient-care a dying friend received from a trainee: "a young Fellow (who had once been a nurse on this unit), who would sit on his bed, talk to him and *listen* to him, *touch* him…help him" (Lokey, 1994, p. 333). The additional descriptors in parentheses, another form of code gloss, also function as metadiscourse through which the author indirectly criticizes physicians. To explicitly criticize physicians rounding, the author uses

capitalization when quoting his patient-friend: "'They don't know me! They come by in a group each morning, ask me how I feel—what do I need…AND NEVER TAKE THEIR HAND OFF THE DOORKNOB!'" (p. 333). Capitalization amplifies what could be read as a simple statement of observation into an emotional criticism.

- The physician-author of "The Question" uses italics as a subversive strategy. He first reports on a cross-disciplinary project in which he interviewed physicians and ministers about psychosocial care. From pediatric oncologists, he received what were in the context of the hidden curriculum surprising answers:

> They told me that talking, not bone marrow biopsy or lumbar puncture, was our discipline's principal procedure;…that our chief responsibility as providers and orchestrators of psychosocial care was minimizing parents' regret when the outcome was bad; that all we could really offer in cases of diffuse pontine glioma was radiation and kindness. (Adrian, 2012, p. 2372)

In subsequent paragraphs, the physician further problematizes the answers. "They said that the skill of recognizing and addressing patients' emotional needs was teachable and not teachable; that they'd learned it or never learned it in didactic sessions" (p. 2372). Finally, the trainee writes, "I think I finally understand": "I can do this work because *talking is our procedure*. It's not so bad being me because *it's our responsibility to minimize parental regret*. I can return to work every day because *sometimes all we have to offer is radiation and kindness"* (p. 2373). The italicized clauses repeat essentially what he had been told—which readers already know—but the code gloss tells us how to reread it: not verbatim, but as the *essence* of what the oncologists

had said. This rhetorical strategy in effect renders the nonscientific aspect of pediatric oncology, the psychosocial, as the most important: a subversive claim in terms of traditional medical education.

- The excerpt from "Meeting Death" (Laux, 2012) shows the use of multiple types of code gloss, all of which underscore the physician-author's argument about the social inequity of death:

> When I was there, the vast majority of people who left Kamuzu Central Hospital by way of the morgue *died*….When there are no IV pain medications—and there weren't while I was in Malawi, at least that I could find—there is comfort only until the complications of HIV or liver disease of whatever else rob one of the ability to swallow. Then, one is left to die the 'natural' way, which has got to be one of the most un-natural things a person can witness." (p. 741)

In all of the examples above, code gloss personalizes the physician-author and resists the forces of medicalization and the hidden curriculum. Whether through dashes, quotations marks, capitalization and/or italicized type, physician-authors draw attention to their agency as individuals who actively contest the culture of medicine. They call out teachings that they feel are unfair; they call into question traditional values and behaviors related to end-of-life care. In other words, trainees problematize the notion of *self-evident* truths in medicine as a fundamental taken-for-granted. Their texts about dying and death argue that self-evident knowledge requires a subject. Accordingly physician-authors rhetorically reconstruct their authorial *selves* through metadiscourse.

Validity Markers

Through the use of validity markers, physician-authors insert doubt into the certainty of scientific knowledge that medicine as an applied science is based upon.

Their experiences with dying patients prompt them to challenge the authority of knowledge grounded on universally observable data. Instead, trainees draw upon knowledge gained through their personal experience; their perception as embodied individuals. Their authority is self-referential, in opposition to medical convention that requires authors always to cite others. As a result, their understanding of death renders it problematic and scientifically uncertain; their encounters with dying patients evidence that death, while a universal experience, occurs fundamentally as an individual event.

Below, I discuss five types of validity markers used prominently by physician-authors in the study corpus: emphatics, hedges, attributors, attitude markers, and commentary.

Emphatics

Physician-authors in the study corpus use emphatics as a subversive strategy to undermine rhetorical conventions of medicine. In the excerpts below, trainees initially utter definite statements about the practice of medicine, which they then contradict. This strategy is used commonly and effectively in disciplines where knowledge is valued as "the product of contrast and competition" (Barton, 1993, p. 754) as it is in medicine. However, physician-trainees use emphatics to contradict traditional epistemologies; the knowledge that "wins" is not what the institution of medicine endorses: knowledge gained through individual perception and bodily experience related to death.

- A family medicine resident draws upon institutional descriptions to articulate how a patient's heart felt to him during a resuscitation attempt: "'Like a bag of worms,'…recalling the term from countless medical texts" (Glazer, 2004,

p. 609). After he is ordered to massage the heart during emergency surgery, however, the resident realizes how little medical texts had prepared him. When the patient is declared dead, "I reluctantly gave up my post at her heart. It jerked futilely for a moment and then seemed to gasp and stop…I walked from the operating room, my shoulders stooped, and my scrubs clinging to my damp back. In the stairwell I started to make my way down, toward the exit. I needed a break, some time to think about what I had just seen" (p. 610). He recalls images of "bloody gloves, the stilling heart, and the motherless infant crying alone in the nursery" (p. 610) and the resentment he anticipates feeling toward the drunk driver whose car fatally injured the patient. The resident concludes with the emphatic--"Introspection is not good medicine during the intern year" (p. 610)—when, in fact, his article is an introspective recounting that can be construed as an argument for interns' need to reflect on the meaning of their encounters with death.

- At the beginning of "Full Code," an emergency medicine resident says of a new semiconscious patient, "I knew his future like the back of his swollen hand" (Veysman, 2005, p. 1311-2). This emphatic is followed by long, vivid descriptions of procedures that the resident says he will use to resuscitate the man. But the patient regains consciousness and chooses to be DNR, which the resident reconfirms several times before completing the necessary paperwork: his primary goal. Then when the patient's girlfriend visits, the patient changes his mind again, leading the resident to conclude, "That night the chart said full code. Tomorrow I would ask again" (p. 1316). By the

article's conclusion, the trainee has revised his own goal: "Emphasis on empathetic communication, not rigid legal documents, is most conducive to doing the right thing" (p. 1316). He arrives at a new understanding of medical practice at the end of life, knowledge that contradicts what he has been taught in training, even though it has been attained through a process of "contrast and competition."

Hedges

By incorporating hedges into their writing, physician-authors are rebelling against the dominance of definite statements as a defining feature of medical discourse. The trainees are inserting elements of doubt into what they say about dying and death. When hedges are used intentionally, they can have the effect of certifying the trainees' authority (Kolln & Gray, 2010), which upends the hierarchy of the medical culture.

- In addition to the traditional war stories doctors tell about their residencies that bond trainees, the intern-author of "Ghosts" (Ives, 2007) claims to access another unique set of narratives: those he invents about the imagined experiences of his doctor-father who died before the intern's birth. "*Maybe* we both took care of someone with congestive heart failure….*Maybe* he also had to tell a young man's mother that he died suddenly in the night….*Maybe* he overslept through morning rounds or got nervous…" (p. 1259; italics added). For a physician to state in the pages of a medical journal that he finds guidance in fictitious stories is a professional risk. By prefacing each claim with *maybe*, however, he assures readers that he is aware of the risk. He also

gives credence to imagination as a source of medical knowledge, an unscientific and subversive rhetorical move.

- The most powerful use of hedges in the corpus is found in the controversial article, "It's Over, Debbie," published in *JAMA* by an anonymous gynecology resident who admits to giving a lethal dose of morphine to a patient he does not know. He begins by making key definite statements. He is paged in the middle of the night to respond to "a 20-year-old girl named Debbie…dying of ovarian cancer" (1988, p. 272). She has "unrelenting vomiting" and is "suffering from what was obviously severe air hunger." The physician-author then makes personal observations repeatedly using the hedge *seem:* "The room *seemed* filled with the patient's desperate effort to survive" (italics added). He injects the morphine and, "[w]ithin seconds…her features softened as she *seemed* restful at last." Besides a nurse, the only witness to the scene is a woman whom the author does not name or note her relationship to the patient. At the end of the article, he observes, "The dark-haired woman stood erect and *seemed* relieved." The trainee uses hedges to attribute emotions to both women: an appropriate rhetorical strategy when the author cannot definitively know another individual's feelings. However, the strategy did not reinforce his authority. Instead, the hedges in particular drew the ire of several physician-readers responding with letters to the editor.[41] The uncertainty of *seemed* underscored what many critics felt was the trainee's

[41] See Vanderpool and Manesis in the April 8, 1988 issue of *JAMA,* and Marshall in the August 12, 1988, issue. Numerous letters criticize the original article for other uses of metadiscourse. Many fault the resident for misinterpreting the only statement he attributes to the patient—"'Let's get this over with'" (It's Over, Debbie, 1988, p. 272)—as a euphemism for requesting physician-assisted suicide.

lack of expertise, judgment, and compassion, drawing into question not only the credibility of the author but even *JAMA* for publishing the article. It is possible, however, that the criticism also could be interpreted as institutional resistance to the trainee's rebellious actions professionally and rhetorically.

Attributors

Writers use attributors, e.g., *according to*, to increase their own authority by referencing experts whom readers are likely to trust. Many physician-authors use attributors reflexively, that is, they comment on their own expertise by viewing their behavior and comments regarding death from the patient's perspective. While this rhetorical strategy might seem to undermine the trainees' ethos, the effect is the reverse: the trainees gain authority by taking a stance in opposition to the traditional one of physician-as-expert, which ultimately dehumanizes the physician, because no one is an expert at dying. In the first two examples below, trainees stand outside their texts, so to speak, where they can comment on how they sound to others: a reciprocal acknowledgement of their shared humanity with dying patients.

- The physician-author of "At the End of the Day" describes his attempt to follow orders to persuade a dying cancer patient not to opt for resuscitation. The 53-year-old patient had spent "years of working in a steel plant" and "serving in 'Nam. He will not be dissuaded by *a young trainee doctor with a foreign accent* and a nurse who might just be trying to save her hospital some money' (Khorana, 2003, p. 242; italics added). While unusual for a physician,

his self-deprecating remark humanizes him, so that later he relates meaningfully with the patient as he dies.

- The physician-author of "Dogwoods" questions his authority when discussing end-of-life care with an elderly patient: "Then again, who am I to tell someone that their life is no longer worth fighting for? I'm only 28…I can relate to almost nothing of what some of my patients have endured…I have often known them for only days, yet I pretend to know what is best for them in matters of life and death" (Wynne, 2012, p. 898).

Attributors also function subversively when physician-authors use attributors to describe themselves as model trainees embodying confidence and ambition, but follow up with critical observations from others. Again, the result is a humane portrayal of the trainee who is admittedly humbled by others—and likely to be chastised by proponents of the hidden curriculum.

- "I was a shy, but cocky, little houseman and I remember coming back from a business ward round….We were particularly pleased with the way things had gone and were preening ourselves on our excellent performance" (Gregory, 1983, p. 757), writes a British consultant. After rounds, the trainee is immediately criticized by another member of the health-care team: "'You've no idea the harm you doctors do,' said Alice, 'I'll have to go round now and try to sort out the pieces'" (1983, p. 757): criticism that literally changes his practice.
- A new intern recalls, "I arrived on the ward at 8 am: white coat clean and ironed. I'd done well in finals and decided that a career in hospital medicine

was good for me. I was to be a brilliant diagnostician and power my way to the top, culminating in my appointment as consultant cardiologist before I was 30" (Lear, 1992, p. 1122). After 1 month of making mistakes, however, the trainee revises his outlook on the future: "Thoughts of careers are now more muddled: my priority has to be to survive this year" (1992, p. 1122).

In sum, whether physician-authors use metadiscourse to comment on their honesty or arrogance, attributors function to individualize the trainees: to set them apart from the scripts and roles they have been enculturated to take on when attending to dying patients--and to let readers know that *they* know.

Attitude Markers

While attributors indirectly tell readers how trainees regard themselves as trusted authorities, attitude markers explicitly tell readers. Their chosen words and clauses disclose how the authors feel about the text's content, which also reveals the character of the trainees. As with attributors of hubris above, attitude markers often convey unflattering self-portraits of practitioners who, when confronted with dying patients, doubt themselves. They do not embody medicine's cultural stereotypes, nor do they convey a humane portrait of medical care.

- When an intern is called to admit a patient, he describes his reaction: "I groaned. Oh no, a train wreck. Patients from the medical intensive care unit always seemed to have twelve complicated problems and a propensity to crash" (Bushman, 19921, p. 313). Since the patient is a transfer, though, he realizes that "I could get away with…an accept note as scandalously short as

'Patient seen and examined, chart reviewed.'…I already had tricks of which I was not at all proud" (p. 313). The intern owns his flaws, but attributes them to the enculturation process that rewards "scandalous" behavior.

- A 3rd-year resident on a pediatric intensive care rotation bluntly describes her attitude toward a patient and her parents. Of the malformed 8-week-old with a feeding tube and tracheotomy, the trainee writes, "'She was hideous.' I felt guilt for the appalling feelings that I experienced every time I examined here. She brought up fears and thoughts that I was embarrassed to think" (Nelson, 2006, p. 791). Other attitude markers she uses include: "I thought, 'Is this any kind of life?'"; "I thought, 'Can [the parents] really look at her and not feel appalled?'" When the infant could not be transported to another hospital, the resident writes, "I thought, 'Damn, would have been good riddance'"; "I thought, 'It doesn't matter WHAT we do…she's a vegetable and she always will be!'" (p. 791).

While the resident owns "my negative emotional response" (p. 791), referring to it "a gap in professionalism" (p. 792) and "countertransference" (p. 791) of "my own fears of having a sick child" (p. 792), I suggest that her attitude markers can be interpreted another way. They are metadiscourse-- "discourse about discourse" (Vande Kopple, 1985, p. 83)—though the discourse the resident is reacting to is the medicalization of the dying infant: "…she had been trached since she was a month old"; "The PEG [percutaneous endoscopic gastrostomy] tube turned into a prolonged course…the baby's belly was distended with feeds, and her respiratory status deteriorated" (p. 791). The resident says she is "appalled by the appearance of this child." Her attitude markers

suggest that she is equally appalled by the inhumane ways in which the infant's life is (not) handled: how medicine objectifies her through language into a sum of diagnoses and abnormalities—the baby is referred to only as "she" for the first four paragraphs—and through the technological apparatus that breathes and "eats" for her. Thus, metadiscourse functions as criticism about the discourse and culture of medicine that prioritizes the imperative to prolong life at all costs.

Commentary

Commentary refers to words or phrases through which the author addresses readers directly, "often appearing to draw them into an implicit dialogue" (Vande Kopple, 1985, p. 85). Most often, physicians-authors use the first-personal plural pronoun *we* to address readers, creating intimacy between physician and reader. Through commentaries, the authors persuade their colleague-readers to join in re-envisioning medical care at the end of life and, as some say, literally to the ends of the world.

- In "Where They Don't Value Life" (Arnold, 2001), the surgeon describes his experiences practicing medicine throughout Asia, concluding:

> Pain is the same. Anguish is the same. Suffering is the same. One of the greatest souvenirs *we* bring home from *our* travels is the newfound ability to see the universal in what on the surface seems otherwise unfamiliar. *We* are united throughout the world with our contempt for the surgeon who sits at home, temporizing with one more test. *We* share in the despair of another young mother who has just lost her child, wherever she may be. (Arnold, 2001, p. 357)

- The physician-author of "Their Simple Sorrows" asks readers to think about what he has seen as a house officer (resident) treating wounded and dying patients in Afghanistan. He issues three imperatives, addressing readers with

> the implicit second-person *you*: "*Think* of them, the doctors of Kabul. *Think* of the people of Kabul, forgotten in their misery. *Think* of the children of Kabul and the children of war everywhere. All they have are their simple sorrows. Perhaps one day some of them will know simple joys" (Hettiaratchy, 1994, p. 1239). He reminds colleagues first to be fellow human beings with those for whom they provide medical care, second, to be physicians.

Emotive Language

Through emotive language, physician-authors flagrantly violate teachings of the hidden curriculum. They protest medical morality by voicing emotions that contradict notions of what is and is not appropriate, and often act upon those emotions in caring for dying patients in defiance of the rational practice of medicine. Trainees acknowledge emotional bonds with patients at the end of life, crossing the boundary into inappropriate professional behavior as they reflect upon their experiences. Most egregious, trainees admit to crying in public: behavior that epitomizes a lack of professionalism. It illustrates trainees' integration of body and mind, how emotions affect their person to the point where they cannot control their behavior. Thus, death becomes not a medical event but an emotional experience for trainees that can force them to confront the inevitability of their own death.

From my findings, I have categorized emotive language in the study corpus into four types: politically incorrect feelings toward dying patients and/or their families; feelings of personal inadequacy and insecurity; detachment and distancing from oneself; and public displays and private experiences of crying.

Politically and Professionally Incorrect Feelings

Contrary to assumptions that science is value-free, the culture of medicine has established distinct "notions of rightness and wrongness, appropriateness and inappropriateness" (Hafferty & Franks, 1994, p. 863). Among them, it is inappropriate for physicians to harbor or express negative personal emotions toward patients in their care: a situation "more ideological than rational" (p. 866), since trainees and practitioners do have affective experiences, particularly in response to death. The examples below show how physician-authors circumvent this morality by implicitly holding the institution of medicine accountable for inciting their negative emotions. Even before they see patients, the residents are prejudiced by the way medical discourse negatively presents patients in medical records. Once they encounter patients, the training they have received leaves them unprepared emotionally, thus person-ally inept in dealing with death.

- In "Nuts" (Rasmussen, 1998), the trainee is put off by the patient he is assigned in the emergency department as he reads in her chart: "'Patient wants to know if she is dying'" (p. 514). The 86-year-old woman demeans him throughout their interview with derogatory comments regarding his age and dress. Finally, the patient asks him point blank if he is a coward, since he does not directly respond to her question about how he rides horses. As he describes it: "I feel like I have lost all control of this interview. 'Are there any doctors here with ex-per-i-ence?' She says, 'experience slowly and articulately as if it might be a world I would have trouble recognizing. I am beginning to feel that if there is going to be dancing on her grave, I want to be

invited" (p. 515). The trainee admits to feeling frustrated, angry, and ultimately, "bad" for failing professionally but more importantly, personally. The patient challenges him, calling out his inability to tell the truth about his own body as well as her prognosis and her body, when she says: "'I think you don't ride [horses] because it racks your nuts'" (p. 515). He was, he later admits, "not completely honest" with her or himself.

- When Reverend X dies unexpectedly in "Dr. Death—Reflections of Death Telling," the family stages "a grotesque wake" (Walthall, 2006, p. 463) in the waiting room, screaming and slamming themselves against the wall. The resident writes, "I then turned to the mother and felt an emotion I can say I have never honestly felt toward another human being—sheer hatred. I couldn't help it. I was overwhelmed by this display, this 'falling out' production that was well beyond my comprehension or experience" (p. 463). Complicating the scene is race—the resident is white; Reverend X's family, African American—though the physician-author writes: "As a side note, I read in one of my college courses called 'Literature and Medicine' that African Americans have an incredible variation in contrast to other cultures in the ways they express their grief." Several days later, however, the trainee realizes that

> I failed the reverend's family…"; "just because I took multicultural classes in college and consider myself an open-minded person, this does not qualify me to judge how and how not to behave. What I have been doing for these years is making people crawl into my pigeonhole of how *I* think people should respond to death and may not just letting people respond to death how *they* should. (p. 463)

The resident implicitly criticizes the medical education system for leading her to believe she could "manage" grieving individuals, particular those from different cultures, and control conversations about death.

- The 1st-year family medicine resident in "Requiem for Mr Bojangles" (Chang, 2002) expresses his dissent in an inventive and subversive way: through the language of music. Initially, he is upset when paged at 3 a.m. to the Critical Care Unit to attend to a patient negatively described in his medical file:

> "...past admissions related to alcoholism and substance abuse and various psychiatric diagnoses. As I looked over at the patient—filthy and unkempt, exuding a variety of foul odours, expecting to die—I thought his medical history seemed to indicate he was asking to die. At that point, I became annoyed because a guy like this was actually keeping me from my sleep." (p. 122)

The trainee's inappropriate response can be rationalized in the culture of medicine by the documented effects of sleep deprivation on the mood and personality of residents.[42] In addition, as physician-author Danielle Ofri points out, "most doctors still hail from wealthier (and healthier) middle-class backgrounds and have far less experience with illness, disability, economic instability, unemployment and prejudice….Patients can seem so different from doctors" (2013, p. 16). What is significant about the resident's response, then, is how he revises it by literally stepping outside medicine's cultural boundaries. After the patient dies, the trainee attends a guitar class where he practices the folk song "Mr. Bojangles." "I suddenly felt a strange sadness as I played these new chords

[42] The Accreditation Council for Graduate Medical Education revised "duty standards," requiring interns to work no more than 16-hour shifts in order to decrease fatigue that could lead to medical errors and personal injuries (Volpp et al., 2012).

in that slow and deliberate sequence: bass pluck, strum, strum. Soon I realized that my sadness was largely due to Mr B's feeble and tragic death"; "Maybe he wasn't such a bad guy" (p. 122). Only when he is distanced from the hospital and the roles he must assume there does the physician-author allow himself to grieve, which then enables him to revise his evaluation of the patient.

Feelings of Personal Inadequacy and Insecurity

Physician-trainees, like other neophyte professionals, frequently voice feelings of inadequacy and insecurity, which they transfer from their professional lives to their personal beings. In the study corpus, however, results show how medical trainees invert this transference. By admitting their inadequacy as physicians-in-training who can successfully detach themselves from dying patients, trainees are able to actualize their selves as emotional, sentient beings. In the process of resisting the detachment taught in the hidden curriculum, they rehumanize themselves.

- The intern-author of "Why Should I Live in Pain?" (Rifkin, 1997) admits, "They call me doctor, but they don't treat me like one. I don't feel like one. And lately I don't always act like one" (p. 372). He is reacting to working night float while trying to studying for board exams—but only in part. He questions just how much he knows—"I know that the letters after my name signify something worthy of the title"—and is certain only of how much he does *not* know. "It is strange to be called something that I don't feel worthy of. Everyone must be able to see this. I feel like a fraud just waiting to be found out" (p. 372). Then, when challenged by a dying patient whom he

describes as even more cynical than he, the intern reassesses himself. "Seeing her suffer stirs up strong feelings in me. It is basic and instinctual. I see her in pain and I want to stop it…I begin to recall why I went to medical school" (p. 373).

- A Canadian resident begins her article with a personal disclosure: "My biggest challenge, when I started my family medicine residency, was managing my insecurity" (L'Ecuyer, 2012, p. 73). She says that "I liked to think that I had good relationships with my patients," until the night she was called to certify the death of an 83-year-old woman: a stroke patient she had been following for 8 months. Just 7 days before, the intern had reassured the patient she was fine, despite her complaints of a vague pain. "Still in shock, it was not until the next day that I questioned my judgment. Was I a bad resident? Had I done a poor job of assessing her condition? I pictured a heated discussion with the family—even a lawsuit. I pictured my supervisor criticizing my lack of attention" (p. 74). Instead, the husband requests that she be his personal physician. "And here," she writes, "was another lesson for me: it is easier to keep a distance" (p. 74); sensitivity and empathy take time to experience and share with patients.
- Insecurity does not always diminish with time, nor does emoting about a death prove cathartic, as several physician-authors attest. In "Trying to Let Go" (Costigan, 1999), the author continues to wrestle with a decision he made as a 2nd-year resident in internal medicine. A 16-year-old girl "in full arrest from a pulmonary embolus…was not responding to all routine measures. We did

> not have streptokinase. A thoracic surgeon was not in the [small community] hospital and was probably 30 to 45 minutes away. None of us knew how to open her chest" (p. 446). The resident called for resuscitation efforts to stop. "The nurse looked at me in horror and disbelief, pleading with me…'You cannot just let her die.'"; "The girl's mother was grief-stricken and begged me to tell her that it was not true." Twenty years later, the physician writes, "I am filled with a mixture of sadness, regret, guilt, powerlessness, and mystery. Why did this happen? Why can't I let her go?" He decides, though, that "[m]aybe there are some experiences that you just cannot, and maybe should not, bury" (p. 446). While emotive language dislodged neither his personal insecurity nor his grief, it rendered the physician more humane in his later years.

Detachment and Distancing from Oneself

Many physician-authors in the corpus describe how they are trained to detach themselves from emotionally volatile experiences and how, particularly when dealing with death, lessons from the institution of medicine ultimately fail them. The trainees simply state their own emotional responses to the ineffectiveness of such a professional stance; declarations that are rhetorically powerful in their honesty and directness.

- In "Death and Medicine: A Personal Account" (Peters, 1990), the author as a trainee was aware that

> more than feeling for the death of the individual, I was aware of how detached I was from the process of mourning. Many times that year, and for the next four or five years of my training, I felt separate from the sorrow—I knew that the death had occurred would have a great

> impact on the family members and friends who survived, but I had no sense of how they truly experienced it. (p. 81)

- The physician-author of "The Cross-Cover Resident" sees herself distanced from the dying infant in her charge, which she initially ascribes to her position.

> I am only a cross-covering resident here in the PICU [pediatric intensive care unit]. I spend every fourth night here, but I miss out on the daytime drama…I don't feel as connected to the patients in the PICU. At times I feel almost like an intruder." (Moreno, 2003, p. 956)

  But she also recalls how she was prepped to distance herself. "I remember that when the baby was returned from surgery on ECMO, more than 2 weeks ago, I was told that he would not likely survive. I think I registered that in my mind and began to pull away from him. I allowed myself to withdraw emotionally from the family. I regret this now" (p. 957)

- In "Reflection on Death" (Newlands, 2011), the physician-author states, "Doctors have to do that. We have to move effortlessly from one patient to the other, 'parking' emotions somewhere in our brains to be dealt with later, or never dealt with" (p. 1072).

- An intern on a leukemia and lymphoma unit describes how "[a]s one post-treatment bone marrow biopsy after another showed disappointing news, I increasingly avoided eye contact with my patients. I approached many days with the intent of being emotionally unavailable—nothing more than a manager of disembodied diseases, laboratory abnormalities and symptoms" (DeBardino, 2011, p. 884).

- In "Time to Care," the author recalls how she had been trained as a 1st-year resident to "reduce my ICU patients to a litany of numbers and organ systems in my progress notes," because these notes "were what the attending physician reviewed to see what kind of doctor I was becoming" (Gaufberg, 2008, p. 846). Still, she was surprised when "[o]nce I gathered an extended family in the conference room to deliver the terrible news that their loved one had just passed away. I allowed for silence, responded to questions, made empathetic statements—just as I was taught in my 'giving bad news' training sessions—but didn't feel what I thought I was supposed to feel" (p. 847).

Public Displays and Private Experiences of Crying

Crying, the epitome of the unprofessional affective response in any discipline, runs counter to medicine's morality, in particular, notions of inappropriate emotionally-driven behavior. The fact that the physician-authors of 33 of the 125 articles—nearly one-third of the study corpus— describe how they cried at some point during their training in a situation involving death evinces the implausibility of physicians successfully denying their personal emotions. References to crying are found in 12 of the 14 journals; the two that do not include articles that mention crying also have the fewest articles in the corpus, *Annals of Family Medicine* and the *Canadian Medical Association Journal*. Also significant is the gender of physician-authors who acknowledge crying: 20 males and 13 females. Descriptions range from squelching the need and/or desire to cry, to likening crying to uncontrollable vomiting.

- In "Internship in Africa: Death and Life," the physician-author chronicles a

day from the first week she spent in Angola: "My first CPR, my second death, all in 30 minutes. I was numb; I wanted to cry and scream and run away. Instead, I kept rounding" (Riviello, 2008, p. 353).

- Another physician allows herself to cry, but does so privately and only framed as a cynical response: "I found myself humming that song from the *Wizard of Oz*—the one that begins, 'I would while away the hours, conversing with the flowers…'" (Gaufberg, 2008, p. 847). "Bob, the rotund and affable ICU nurse, hummed it all night long while adjusting vents and tubes. Then I recalled with a sudden start the rest of the lyrics—'if I only had a brain…if I only had a heart'—and laughed until tears sprang to my eyes. My outlook wasn't always so dark."
- During his internship, a physician recalls when he was asked by a father to explain what happened to his son whom the intern refers to as a "floppy, grotesquely swollen infant" who is "unlikely to recover neurologically" (Schultz, 1994, p. 1146). "I am unable to say anything." He tries to hold back, but cannot:

> [g]rief rises into my throat. 'I…excuse me,' is all I can say, and before I can even get out the door the tears start. I walk quickly past the nurses station, and the sobs begin, like a vomiting spell that can be suppressed only so long, and once started cannot be controlled…I duck into an unlit conference room, lean against the wall, and surrender to it, purge myself…of the cynicism…of sleep deprivation, of the insecurity of internship." (p. 1146)

Bernard Siegel, the physician-author of several best-selling medical books for lay audiences including *Love, Medicine, and Miracles* (1986), responded to this article and a similar one in a letter to the *JAMA* editor: "I am out of my mind over A Piece of My

Mind. Again and again, physicians are crying in deserted corners of the hospital. Why is this happening?…our lack of training and the depersonalization that had become a part of medicine" (1994, p. 659). In his response to Siegel, the intern-author concurs: "His assessment that our medical education does not adequately address a physician's own emotional response to patients is an understatement…[it] was never discussed" (Schultz, 1994 b, p. 659). The intern then adds a plea of his own for "fellow physicians…to cry in public. The act of grieving is itself a powerful link to our own humanity. We must first be comfortable with grief and its display within ourselves before we can share it."[43] Others have echoed Schultz in the intervening 20 years, but largely to no avail: "these appeals have not led to pervasive curricular changes because they pose challenges to the existing cultural norms of medicine," namely, "emotional detachment, affective distance, and clinical neutrality" (Shapiro, 2011, p. 328).

Nonetheless, Shapiro's article supports my claim that is backed up by the study corpus: that personal writing subverts the hidden curriculum by contesting the "*tacit* commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity" (Coulehan & Williams, 2001, p. 598). Physician-authors are exercising their *authority* through emotive language, giving voice to personal affective responses to death

[43] The only other article in *JAMA* that references physicians' crying appears in 2001, "Crying in the Curriculum," in which Nancy R. Angoff, a medical educator at Yale University, reports on results from her 2-year informal survey of 3rd-year students at the end of their clinical rotations. She found that 133 of the total 182 students said they had cried at least once; 30 were "on the verge of crying," and 19 denied crying (Angoff, 2001, p. 1017). "In only one story did the physician stop the work of the day for the team to talk about the death that they had shared and to eulogize the patient" (p. 1018). Angoff notes that "emotional development takes place in the realm of in the informal [hidden] curriculum." She warns that if students are trained in a clinical environment that "ignores or devalues compassionate responses," they are more likely to become "cynical physicians." The physician concludes by stating, "We ought to model and commend compassion and react to the deep feelings of our students in the same way we would teach them to react to the deep feelings of their patients—thoughtfully, respectfully, and honestly" (p. 1018). Angoff's article--printed in the section "A Piece of My Mind," not as an original research article--has been cited 19 times in 13 years.

that are silenced by professionalism. The potential for their personal writing to influence the hidden curriculum would be stronger, I contend, if it were recognized as another formal genre of medical discourse.

Rich Features That Obscure Medical Rationality

Euphemisms

Findings from my analyses show that euphemisms in the corpus blur judgments about trainees' responsibilities, emotional as well as professional, toward dying patients. The vague expressions replace direct phrases, thereby softening the moral impact of trainees' decisions per the hidden curriculum. Trainees absolve themselves of alleged wrongdoing; they refuse to accept cultural expectations that fault them for not preventing patients' deaths. They further subvert the institution of medicine by arguing for euphemistic diagnoses that are more accurate, though less precise, than standard medical discourse to identify how individual persons react to death. Thus, trainees discursively respect the power of death in medical settings.

I discuss four recurring examples found throughout the corpus: two euphemisms that are substitutes for death and dying, *gone* and *loss*, respectively. These phrases are in direct opposition to the *AMA Manual of Style*, which states that "directness is better" (Iverson et al., 2007, p. 325). I follow with two examples of what I refer to as "reverse euphemisms" that incorporate vague, nonscientific terms into medical discourse.

- In "Mourning on Morning Rounds," the trainee refers to "*the passing*" of an elderly patient; "She was *gone*" (Vallurupalli, 2013, p. 405; italics added). Another article begins, "He might *go* this weekend" (Lodge, 2010, p. 56;

italics added). Still another begins: "I looked up at the tired, scared man staring intently at me and said, 'She's *left us*'" (Guardiano, 2009, p. 500; italics added). These euphemisms frame death as an action performed, perhaps even chosen, by the patient—*passing, going, leaving*—which absolves those who remain of any responsibility for the death. More importantly, the words elide the finality of death, likening dying to simply leaving a room, which further carries the possibility of returning. [44]

- Another euphemism frequently used in the corpus refers to dying as *loss*: "We all had heard stories of interns *losing patients* on their first day…" (Buxton, 2011, p. 784); "Somehow *losing someone* so young…" (Halvorson, 2003, p. 246); "*Losses* are frequent in the ICU" (Vallurupalli, 2013, p. 405; italics added). As the medical student-author of the latter article explains, "the loss of a patient is a common form of maladaptive coping, particularly among trainees"; "In the wake of [the patient's] death, the intern and I also suffered alone, grasping for some sort of emotional closure, for some sort of meaning in what we did not fully understand." To say the trainees *lost a patient* softens "a sense of failure." The euphemism "gently" resists the medical imperative--doctors are to prolong lives; to do anything else is to fail—and helps to absolve trainees of any moral wrongdoing.

[44] Two trainees take a traditional stance and argue against the use of euphemisms at the end of life, because they confuse patients. An emergency medicine resident says that "I learned to use the word 'death' when telling the family that someone died. Though it may sound harsher than 'passed on,' 'better place now,' or 'with God,' it is less likely to inspire confusion or false hope" (Prystowsky, 2006, p. 289). Another emergency medicine resident remarks that "It became clear to me after 10 minutes filled with delicate speak and death euphemisms that neither the patient nor his mother understand the gravity and impending doom" (Bassett, 2008, p. 178), an otherwise astute observation were it not for the trainee's own euphemistic use of *impending doom*.

- Several articles in the corpus argue for what I call "reverse euphemisms," which undermine professional distancing called for by the hidden curriculum. In "The Laying on of Hands" (Weinberg, 1992), a fellow whose brother is diagnosed with lymphoma suspects that he, too, has cancer when he begins to suffer intense chest pain. He orders numerous tests for himself, then finally makes an appointment with an internist who "tried to be 'academic'" but is definitely "not a rising star" (p. 183). Rather than a diagnosis, the internist gives the trainee what he pejoratively considers a euphemism. "'Heartache?' The word struck me like a slap to the face. 'Yes. Your brother is seriously ill…and you've served as his personal physician….You love your brother very much, and so you feel his pain in your heart'" (p. 84). The trainee realizes, however, that "once Dr. Davidson had called the name of the demon, its power was vanquished"; "We have learned of the pain that disease brings to mankind and know that often we are powerless to stop it. And when the thin veneer we erect to protect ourselves from this knowledge is shattered, demons that lurk in our minds are unleased to terrify our souls." Rather than soften the pain, the "reverse euphemism" strips medical discourse of its emotional protection, which ultimately enables him to heal.
- An intern in Angola describes a similar experience when the granddaughter of a former patient is brought back to the clinic. The intern still blames herself for the older man's death from cerebral malaria. Six weeks later, however, she has witnessed so many deaths that "I think in experiencing death, perhaps I am also learning about life" (Riviello, 2008, p. 354). Thus, when the

> granddaughter's chest radiograph is normal, the intern trusts herself to say "in my pidgin Portuguese…that the little girl might be missing her grandfather. The pain of his death was still piercing for me when I allowed the thought to cross my mind. The mother of the little girl, the daughter of my now-dead patient, nodded in agreement. We hugged" (p. 354). The fact that the intern voices this seemingly unprofessional but nonetheless accurate diagnosis-- *the pain of his death* as the cause of the girl's chest pain-- in "pidgin" or mixed language is significant. It underscores how the trainee rhetorically combines the voice of medicine and the voice of the lifeworld to subvert the culture medicine in order to practice as a caring professional.

Metaphors

My findings show that physician-authors consistently use figurative language, an obvious rhetorical tool that differentiates personal writing from conventional medical discourse, to point out deficiencies in the culture of medicine in terms of death. Metaphors enable trainees to articulate what is inexplicable when they come face to face with death and the aftermath of grief. The indirectness of metaphorical language conveys the complex and conflicting quality of professionals' personal responses to suffering. Figurative language allows exploration of trainees' moral distress by drawing upon imagination as well as reason; it blurs boundaries between personal and professional, providing new perspectives and insight into the unresolvable problem of dying, whether a patient's or thoughts of the trainee's own. The metaphors physician-authors use reach beyond medicine's rationality, referencing disciplines where truth can be individual and

elusive, thus appropriate for querying what it means to die.

The *AMA Manual of* Style dissuades authors from using clichés—"At one time they were clever metaphors" (Iverson et al., 2007, p. 325)—in addition to idioms, colloquialisms, slang, and coined words, all of which are considered unruly: they "cannot be understood literally"; "are not governed by rules"; and "are characteristic of informal, casual communication" (p. 324). Unruly discourse, however, characterizes not only physicians' personal writing but their uncertainty and ambivalence toward death and its place in the practice of medicine. I discuss three predominant ways in which metaphor as a rich feature of physicians' personal writing is used in the study corpus to resist medicalization and the hidden curriculum: as descriptive words/phrases in sentences, recurring metaphors, and article titles.

Descriptive Words and Phrases

Metaphors reveal how physician-trainees use imagination as well as reason to understand death, an epistemology that unites their abstract thinking with their bodies as "sensory-motor enactments" (Lakoff & Johnson, 1980/2003, p. 258). The indirectness of the metaphors expresses for trainees what conventional medical discourse fails to convey.

- In "Princess Abra," a hematology-oncology fellow attempts to make sense of the seemingly senseless death of pediatric patient dying from a brain tumor: "Her pupils, which had nearly vanished from the morphine, were now wide black mirrors that foretold a wide black tomorrow" (Moorehead, 2008, p. 80). Her eyes portend her death, but more importantly, the fellow's grief, which, he says, is "too much" for him to describe. The image of *wide black mirrors*

shows what he means: grief so dark and deep he cannot see through it to discern the meaning of death.

- A British registrar (equivalent to a U.S. resident physician) writes in "Peace and Pain" about her own experience carrying to term and delivering a fetus with multiple abnormalities. Metaphorical language enables her to describe the complexity of her emotions, including her ambivalence about abortion. Three days after receiving results from an ultrasound, she refers to "the initial horror of this 'thing' inside me" (Palmer, 1994, p. 279). Yet, she and her husband realize that "*the piece of driftwood* which we found and clung to was that even this tiny, damaged life was precious and should not be abandoned" (italics added). *The piece of driftwood* refers both to the fetus's body adrift in amniotic fluid as its existence deviates from the expected path of healthy development and to the parents' new realization that allowed them to survive the "horror" that at first had threatened to emotionally drown them.

Recurring Metaphors

Since the study corpus focuses on a rather narrow category of physician-trainees' experiences—encounters with dying patients and death—similar metaphors are found in multiple texts. I discuss briefly two types that are used by physician-trainees to express their personal emotions. Although metaphors are indirect expressions, trainees use them to directly criticize medical professionalism and often, to cross boundaries into emotional territory deemed inappropriate. Thus, the metaphors give materiality and reality to trainees' emotions.

Space

Spatial metaphors are used repeatedly by physician-authors to convey the intimacy of medical practice: the physical, emotional, and psychological closeness that brings together patient and provider. Although the hidden curriculum discourages such intimacy, trainees not only acknowledge it; they interrogate its meaning to learn how to incorporate intimacy into their future professional practices.

- At her 13th interview in "The Story between the Pinstripes: Interviewing for Internal Medicine Residencies" (Margalit, 2007), the trainee-author chooses not to share yet again the story of how her mother's death inspired her to pursue medicine. Repeating the "painful and sacred memories" (p. 518) left her numb; "The story has lost authenticity, and that is shameful to me" (p. 518), which she realizes is "an invaluable lesson": As a physician, she must "remember to deliberately carve out a space of the experience that is separate from the rest," "rubbing off the polish, slouching, and being true to the rawest emotions I feel," so she can "remember to seek the individual across from me, hidden behind the suit or behind the gown, to honor the story shared in the sacred space between us" (p. 518).
- Sharing the intimate experience of death can be unbearable, prompting trainees as well as experienced physicians to seek sanctuary outside their clinical confines in order to gain a new "nonmedicalized" perspective. An emergency medicine resident on a medical mission in Saudi Arabia recounts a tragic mass stampede in "Sandstorm in the Emergency Department" (Khan, 2006). Three hundred sixty people on a "symbolic visit to Mecca" (p. 1342)

died; he helped treat more than 250 who came to the hospital. Afterwards, a hospital administrator "took me to a 'secret location,' in other words, the hospital roof, to watch the sun set on this tragic day." From above, he re-envisions "the largest annual human gathering on the planet" as an assemblage of individuals "return[ing] to their divine obedience" just as "I returned to mine in the ED."

- A female internal medicine intern seeks to escape "The Fraternity that is Medicine" (Lanzarone, 1991, p. 1663), which "requires that members must survive rituals of pain before they can enter the fold" (p. 1663), including adherence to the medical imperative. The intern finds temporary relief every morning before dawn when she distributes sandwiches to homeless individuals sleeping on the sidewalk. She discovers one day that "the woman with the spidery hands" who is "embalmed in layers of worn woolens" has no pulse. Rather than try to resuscitate her, perhaps against the woman's desire, the intern calls the police: a decision that she believes honors the homeless woman, not the imperative to prolong life at all costs. The decision came to her "from a distant corner of logic…that had been obscured by the harsh tint of those hospital lights." Here, "on a cold, dark sidewalk," the female intern realizes, she practices medicine as a humane art, caring for the whole person.

Fabric and Materiality

In defiance of medicalization, physician-authors write of the permeability of professional boundaries in medicine, which they convey metaphorically through the

fabric of physicians' white coats and hospital privacy curtains. Both give materiality to affective qualities that are not seen; to the emotional vulnerability that is not given weight in medicalized models of patient care. Through metaphors, trainees learn to negotiate for a more human and humane practice of medicine.

- In "Lessons from East Africa" (2010), the physician-author criticizes medicine's efficiency when caring for the newly dead. While serving an international medicine mission, the intern is surprised when no code is called when a patient stops breathing. Instead, "within minutes, the nurses covered the patient with a wrinkled white sheet and wheeled away the squeaky, rusty bed to make room for the next of many patients lined up in the hallway" (p. 393). Though "[f]rozen with disbelief," the intern feels as inadequate as she did witnessing her first death in the United States when "my white coat seemed too white and too short to add any of my own words of consolation."
- The resident-author of "Dogwoods" (Wynne, 2012) is frustrated by an elderly patient's refusal to acknowledge her impending death; she suffers from two types of cancer, pneumonia, and urinary incontinence. Later, he realizes that he did not respect her as a person. "I wonder if I have been using the wrong approach. 'Do you want to be put on the ventilator?' 'Should we perform CPR?'…Perhaps I should have put away the white coat with Mrs. M." (p. 898). Without his medical uniform, "I would have asked her about her life. What brought her joy?...I could have asked her what—at 81—she hoped to accomplish with the time she had left. What was she *living* for?" (p. 898).

- In "Empty Pockets," a resident places his trust in the medical imperative only to have it, like his white coat, ripped apart. He tries tell the husband of a 36-year-old woman that she just died, but "I didn't, couldn't, say a word. I took in breath to begin, and he knew" (Pickrel, 2003, p. 39). The man's young daughter, however, did not. "She said words that made 6 years of medical school, residency, and late nights too numerous wither. 'Give mommy more medicine. She'll get better, but you have to give her more medicine, please.'" The girl pulls on the pocket of the physician's white coat, and it tears. When he arrives home, his face tear- stricken, and sees his 33-year-old wife, the resident throws his white coat in the trash. "…all I could say was, 'That one doesn't work anymore.'"
- In "The Curtain" (Boyte, 2002), a pediatrician attends the funeral of an 8-year-old patient where he must once again allow himself to "be vulnerable to the elements of grief and would experience the ravages of emotion. Indeed, I felt intense sorrow, loss, anger, and frustration. But I also realized that her family's pain and grief were much greater than mine could ever be" (p. 245). He had discovered the value of the metaphorical curtain as a medical student observing a failed resuscitation: "On one side of the curtain were lighthearted jokes and camaraderie. On the other side, as bad news was broken, faces were held in serious expressions" (p. 244). The curtain allows a physician "to rise about the emotional impact of death. I am a professional. I am touched, outraged, saddened, guilt-ridden, and horrified, but I am able to place my emotions behind the curtain" (pp. 244-45). The curtain, however, did not hold

up when the trainee's father died during his residency; it became "a barrier to communication" (p. 245).

Article Titles

Metaphorical articles titles are used by physician-authors to criticize the culture of medicine on two levels. In terms of individual articles, metaphorical titles reveal how physician-authors negotiate the conceptualization of the work of living with how they actually live, often in defiance of cultural expectations that *being* a physician means *living* as a physician and setting oneself apart from others. In terms of the study corpus, the metaphorical titles problematize a conceptual metaphor (Lakoff & Johnson, 1980/2003) dominant in medicine, namely, *medicine is rational.* To find meaning in medicine, trainees look outside the culture to fictional literature, foreign language, and mythology, respectively, in the examples that follow. Thus, the knowledge necessary to become a physician and to practice medicine is contingent upon other disciplines and other ways of being.

- The physician-author of "Ascending the Magic Mountain" draws upon Thomas Mann's novel *The Magic Mountain* (1924/1969) when describing the impact of his experience as a tuberculosis (TB) patient at a time when the disease was often fatal. As a trainee, he was sent to Canada's Royal Edward sanatorium after a routine chest X-ray required for residency was positive. "This was the magic mountain where tuberculosis became a way of life" (Bayne, 1998, p. 517), he writes of the sanatorium. Long featured on medical humanities reading lists, Mann's novel is about a character who meets a

variety of TB patients at a Swiss sanatorium for whom the disease has different meanings. Bayne's real-life experience follows a similar plot: "I had left the confraternity of the diseased, but my view of life had been utterly changed" (p. 518).

- The title "On Speaking a Foreign Language" (Anders, 1989) refers literally to the exchange in Spanish between doctor and patient, but metaphorically conveys what the resident understands as the foreignness of fear and death that defy articulation, much less translation. The trainee-author is curious to listen to his attending, a Puerto Rican national, address a patient in their native Spanish. As the trainee observes the physician talk to the patient and his wife, confirming the diagnosis of metastatic cancer, the resident realized "that for them, Dr. Mendez was probably also speaking a foreign language. How could they fully understand the deep meanings and implication of 'maligno' or 'metastasico' while their minds raced with fear through the eventualities of this inevitable death?" (p. 133).
- The physician-author of "The Sharp Edge of Damocles" (Self, 1999) finds in mythology a central metaphor that allows her to restructure her identity as a cancer survivor and a mortal physician. As a 16-year-old, she was diagnosed with osteosarcoma and had her leg amputated above her knee. "'The Big C' mentality of society had already stuck, and despite the months in hospital I do not recall anyone telling me that I could survive" (p. 339). "Memories of the chemotherapy and radiation I have received sometimes haunt me. When these fears occur, rationality and clinical acumen disappear, and I become a cancer

> patient trying desperately not to panic," writes the psychiatric senior house officer. When she learns that the myth of Damocles is used to understand "the psychosocial stresses experienced by survivors of childhood cancer" (p. 399), the trainee reinterprets her terror and dread in terms of the Greek legend: the sharp edge of a sword hung over Damocles' head at a banquet, an "ever present threat of untimely death." The metaphor rationalizes her irrational behavior as a physician-trainee in a way that neither traditional medicine nor medical literature ever could.

Conclusion

Findings from my discourse analyses are significant on two interrelated levels: On the level of discourse, results prove that physicians' personal writing published in medical journals is rhetorically distinct from other types of medical discourse. The identification of salient patterns of five rich features across the study corpus also supports my claim that, for physician-trainees, death is an exigence that brings about a discursive response. On a conceptual level, results also illuminate values of the culture of medicine that have been shaped by medicalization in the past 60 years. Equally important are the naive or unfiltered responses to these values from physicians-in-training who are not yet fully enculturated. Their accounts of experiences attending to dying patients and newly dead patients bring into view a collective resistance to the tacit teachings of the hidden curriculum, attitudes that challenge and circumvent taken-for-granted aspects of the practice of medicine, in particular, the depersonalization and dehumanization of physicians as well as dying patients.

The identification of five rich features that characterize physicians' personal writing about death—repetition, metadiscourse, emotive language, euphemisms, and metaphors--provides a framework that can be used to evaluate the rhetoricality of physicians' personal writing on other topics, for the interrogation of specific textual examples from the study corpus reveals what this type of discourse does, not simply what it lacks as previous studies have shown (Barton 2002; Segal, 1993). Physician-authors use rhetorical tools to argue for the credibility of personal perspectives when writing about encounters with dying patients in the profession of medicine. They endorse a conception of medicine as a first-person practice. Physician-authors value authority based on the experiences of embodied subjectivities who find meaning through mind and body: reason, imagination, and sensibility. Actively practicing medicine involves a person as an integrated whole, a fully human being who can relate humanely to others, especially those facing death. As trainees tell it, death is one of the defining events in life and the profession of medicine. Yet, medical discourse alone is insufficient to describe or define what transpires when patients die, as physicians-in-training evince by incorporating into accounts of their experiences the discourse and literature, the perspectives of others.

Through the use of rich discoursal features, physician-authors also rebel conceptually against conventions of the culture of medicine, for rhetorical strategies reveal values upheld by a culture as well as those that are contested. Trainees, in caring for dying patients, can neither emotionally detach themselves nor distance the physicality of their bodies from those in pain and suffering at the end of life. When they try, adhering to boundaries separating personal from professional per the hidden curriculum,

trainees experience moral distress, a condition that presents in the corporeality of their own bodies. The result is physical distress, often to the point where intense emotions elicited by an encounter with a dying patient overwhelm trainees who cannot repress their feelings. They cry, their personal emotions overtaking the professional control of their behavior. Then, against tenets of professionalism, they write about their experience and share it publicly in a medical journal. The trainees' discursive responses to the exigence that death presents in the practice of medicine become a social response. Their behavior reflects their attitudes; their resistance to the medicalization of death in the culture of medicine. No longer can they rationalize death. To attend to a dying person brings their own person into the picture; to care for another at the end of life foregrounds their own mortality, their humanity.

Although the discursive expression of physicians' emotional responses to death is not a new phenomenon, this dissertation is among the first, if not the first, study to collect personal writing by physician-trainees about their experiences with dying patients published in medical journals and to identify patterns of rhetorical strategies used across the corpus. In this context, findings of the discourse analyses are significant for they show that physician-trainees continue to experience moral distress and to respond with articles published in professional journals. Even 20 years after identification of the hidden curriculum and numerous efforts in subsequent years by medical educators to counter the negative teachings through courses in medical ethics and medical humanities, interns, residents, and fellows remain conflicted about death. However, if the rich features identified are used to identify physicians' personal writing as a distinct genre, as I argue they should, trainees can have another resource, another body of literature within

medicine to consult when trying to make meaning from their encounters with dying patients, which may help (re)verse the abstract and unhealthy relationship between body and mind that undergirds traditional medicine.

CHAPTER 6

NARRATIVE DISCOURSE ANALYSIS: THE *TELLING* OF DEATH TELLING

Introduction

Physician-authors predominantly use narrative to tell of their experiences as trainees attending to nearly and newly dead patients. Findings show that of the 126 individual articles collected, 120 feature personal narratives, defined in earlier chapters as the temporal and/or logical ordering of life events by an individual so as to give them meaning. Whereas the rich features discussed in Chapter 5 reveal attitudes and values in a theoretical sense—physician-authors' use of specific rhetorical strategies connote how trainees understand the concept of death--narrative as the key rich feature discloses trainees' empirical or practical experiences relating to dying and death. Physicians recount the moral distress and physical discomfort they experienced as physicians-in-training when behavioral norms in the culture of medicine conflicted with their own ethical principles. On an institutional level, then, physicians' narratives of their personal experiences function as oppositional stories (Linde, 2001; Nelson, 2001). They oppose the narrative trajectory of ideal physician development called for in the hidden curriculum (Hafferty & Frank, 1994), which tacitly teaches trainees to detach and distance themselves from the suffering of patients, from bodily and affective

identification that impairs the requisite veneer of professionalism. Furthermore, narrative analysis uncovers how physicians use their authority to oppose medicalized time. Physician-authors reposition their selves temporally, transforming their experiences with dying persons from a linear chronology of clinical events into a complicated and nuanced understanding of time as multidimensional: the unity of past, present, and future. Death is neither a disruption in the sequential formation of their professional identity nor a medicalized conclusion or ending that restricts patient care to "winning" or "losing": celebrating the resuscitation of terminally ill patients and temporalizing death, or chastising the failure of individuals and their lack of ability when patients die. Rather, opposition narratives tell how physician-authors reconceptualize death as an invitation into "a deeper experience of time" (Ricoeur, 1991b, p. 165) through which they compose their subjectivity. Reflection affords physician-authors the perspective to see who they are simultaneously with who they were as trainees and who they will be as practicing physicians, and to integrate these into the composition of their own personal identity: persons able to attend to patients with a sense of shared vulnerability and compassion.

These practical findings from the narrative analysis of the study corpus expand upon those of the previous chapter, and thus elaborate upon the response to my second research question:

> ***RQ#2:*** *What does the genre knowledge articulated by necrography tell us theoretically about medical practitioners' behaviors and attitudes toward death?*

Instead of disclosing behaviors and attitudes in a theoretical or abstract sense, physicians' narratives tell how trainees attempt, and often fail, to enact technical procedures and to adopt standardized strategies for end-of-life care called for by the hidden curriculum.

Not only are dying patients reduced to failing bodies unaffected by the person's cognitive and affective capabilities in these cultural narratives; physicians-in-training are reduced to fulfilling one-dimensional roles as rational providers whose personal emotions and beliefs regarding death are superfluous. In response to this set of problematics, physician-authors recompose medicine's oppositional view of mind and body into a reciprocal relationship, which they enact as humane professionals attending to fellow human beings. Their narratives provide insight into new ways of *being* a physician that allows for the integrity of trainees' professional self as a whole person who practices holistic, humanistic care.

In this chapter, I elaborate upon these findings from my analysis of three key narrative elements--complicating actions, evaluations, and codas—with examples and excerpts from the study corpus. Figure 6.2 is a schema of narrative elements in the order they will be discussed in this chapter.

Definitions

Narrative Applicable to Personal Experience

Narrative is a slippery term often used by academicians across disciplines without an explicit definition. In the tradition of scholars in discourse studies and rhetorical genre studies, I use an updated version of Labov and Waletzky's (1967) original definition that has been revised so as to apply to written as well as oral accounts (Johnstone, 2000, 2008): a narrative is a sequence of events that make up an individual's actual experiences usually recounted in the order in which they occurred. More recently, the definition has been expanded as well as qualified, rendering it more useful for written

DEFINITION
- Narrative *Applicable to Personal Experience*
- *Formal Narrative Structure*
- *Political Effects of Narrative*

SIGNIFICANT NARRATIVE ELEMENTS
- *Complicating Actions at the End of Life*
  - Protocols: Procedures Provided
  - Practice: Situations Encountered
  - Liminal: Unprecedented Settings
- *Evaluations as Explanations of (Inexplicable) Emotions and Cognitions*
  - Professional/Social
  - Emotional/Psychological
  - Existential/Ontological
- *Codas as Challenges to Clinical Time*
  - Discordant and Concordant Events
  - Emplotment and Configuration
  - Profound Time and Narrative Identity

Figure 6.2. Schema of Narrative Elements in Order of Discussion.

narratives that can be more complex than oral versions originally studied: "'Personal narrative is a way of using language or another symbolic system to imbue life events with temporal and logical order, to demystify them and establish coherence across past, present, and as yet unrealized experience'" (Ochs & Capps quoted by Johnstone, 2008, p. 155).[45]

The definition of *narrative* used in his dissertation, as noted in Chapter 2, derives from narrative discourse analysis, or as it sometimes called, narrative analysis, a nonliterary analysis of narrative. Narrative analysis allows for a structural analysis of

[45] Five articles in the study corpus do not qualify as narratives, according to the definitions cited. However, I have retained the texts, because they are significant. For one reason, they illustrate by default a critical distinction between *statements* of personal experience used to structure arguments and *narratives* of personal experiences. In Appendix C, I elaborate upon these differences as I discuss components of Ochs and Capps' definition of narrative in relation to the five "non-narrative" articles that tell of trainees' experiences with dying patients and death. In Appendix D, I discuss the unusual form that four other narratives take: a script, fairy tale, utopian fantasy, and a malapropism.

narratives at multiple levels—words, clauses, texts—in order to examine how narrative gives coherence to individuals' lives; helps humans makes sense of themselves as individuals and as members of a group; and shows how social reality is discursively constructed. In addition to these primary functions, narrative analysis offers a morphology developed by Labov and Waletsky: a formal narrative structure based on the identification of four different types of clauses that are joined in particular temporal orders. Johnstone modified these into five stages or functions of narrative: *orientation,* a group of clauses that introduce the situation; *complication*, clauses that "recapitulate a sequence of events leading up to their climax"; *evaluation* in which the narrator states what is interesting or unusual, thereby encouraging the audience to keep reading or listening; *result* or *resolution*, the final events that resolve the narrative's tension or suspense; and *coda,* a summary or a suggestion as to how the narrative of the past relates to the present.

In discussing my findings from analyzing physicians' personal narratives in the study corpus, I focus on three of the five stages identified--*complication*, *evaluation*, and *coda*—since they yielded the most significant results pertaining to my research question.[46] These particular elements also highlight how narrative analysis reveals "the

[46] Fewer than half of the narratives include abstracts. All include orientation, the second narrative element, which introduces the situation in terms of temporal setting, characters, and geographical setting (Johnstone, 2000, p. 638). Several aspects of orientation are worth noting. Twenty narratives are set during late night or early morning hours. Working long shifts without sleep has been shown to negatively impact residents' mental wellbeing (see Chapter 5). That only 16% of the narratives were set during night shifts when death is more likely to be problematic for trainees emotionally and psychologically suggests that trainees' anxiety attending to dying patients cannot be attributed only to burn-out. Regarding characters in the corpus narratives, 37.6% were pediatric or adolescent patients: 30 of the 120 narratives featured pediatric patients and 17, teenagers and young adults. This finding suggests that trainees find emotional and philosophical responses to dying and dead adults as problematic as encounters with dying children who, as dependent beings, often elicit more sympathy and pity (Rowlett, 1990). Geographical setting is the final aspect of orientation I looked at. Nine of the 14 journals published narratives about physician-trainees' experiences outside the United States and Britain. Although the 16 total narratives represent a small fraction of the corpus—13%—the issues they raise regarding cultural traditions surrounding death and the perspectives

political effects of narrative" (Johnstone, 2001, p. 644); how power is discursively produced by individuals, groups, or cultures. Narrative is "a resource" (p. 644) not only for dominating others, but also can be used for resistance as well as negotiation. The institution of medicine uses narrative to "create and reproduce its identity by the creation and maintenance of an institutional memory" (Linde, 2001, p. 518). What has not previously been shown is how physician-trainees use narrative to create "oppositional stories" (p. 529) or "counterstories" (Nelson, 2001, p. 6), which I argue reverse medicine's cultural teachings. Trainees' accounts of their personal experiences with dying patients are "countermemories" or "counterhistories" (p. 518), which not only criticize medicine's paradigmatic narratives but subvert the unhealthy professional identity formulation of physicians called for by medicalization.

Significant Narrative Elements

Complicating Actions at the End of Life

The complicating action, or complication, of a personal experience narrative is "the point of maximum suspense" that "create[s] tension that keeps the auditors listening" (Johnstone, 2008, p. 93), according to Labov and Waletzky's original narrative structure. Although denoted as a single action, the complicating action may consist of multiple narrative clauses relating a sequence of events. This sequence of events is re-examined and expanded in Labov's later theory of narrative preconstruction, in which he proposes looking backward to the beginning of the complicating action in order to better

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they present on medicine and humanity are significant. These are addressed in the discussion of "liminal" complicating actions later in this chapter.

understand why narratives are told. This process reveals how an "unreportable event" (Labov, 2007, p. 49) becomes "reportable" or "tellable" (p. 48) through a regressive chain of events. In other words, the complicating action is an ordinary or routine event that becomes exceptional or unfamiliar, thereby disrupting the equilibrium of expected circumstances, which then prompts the telling of the narrative to a listener/reader who wants to know what happens: how the tension created by the unexpected is resolved.

Findings from my regressive analysis of complicating actions in narratives of dying and death disclose the moral reasoning of physicians-in-training as they question the efficacy and validity of end-of-life practices. By tracing chains of complicating actions, we see how trainees struggle with tacit demands to act professionally, to show detached concern toward dying patients. When their actions conflict with their personal values, when their professional self is morally inauthentic, physician-trainees experience physical distress. Complicating actions, then, reveal an underlying tension in physician-trainees' narratives: resistance to the presumed rationality of medicine and the fear rationality engenders by silencing the reality of death and the personal and physical impact it has upon trainees.

In the study corpus, I identified 11 recurring complicating actions: events, situations, and procedures referenced by physician-authors in their narratives about caring for patients at the end of life. To differentiate the events, I grouped them into three general categories: *Protocols*, medical or professional procedures performed during the care of dying patients, which are learned cognitively; *Practice*, situations encountered in medical practice that elicit trainees' physical and affective responses to dying and death as they experience these situations; and *Liminal*, end-of-life events in geographical

settings where English is not the first language, although the postgraduates experiencing the events have been trained in western medicine and western cultural conceptions of death. In Table 6.1, Categories and Types of Complicating Actions, the different kinds of complicating actions are listed and the number of each found in the corpus narratives. I should note that the total number of complicating actions—167--differs from the total 120 narratives in the corpus, because some articles incorporate multiple narratives and/or complicating actions. For example, in "Trying to Let Go" (Costigan, 1999), the physician-author recounts what he unequivocally considers a mistake that he made 20 years ago as a trainee: he called for the medical team to stop resuscitation efforts on a 16-year-old female patient. Although the primary complicating action is a medical mistake, the author cites two additional complicating actions: how he confronted the girls' dying body and pronounced her death. Occurrences of multiple complicating actions were found in every category listed in the table below; only in one category did the number of narratives with multiple complicating actions equal half of the total articles. Sixteen of the 32 narratives that had complicating actions identified as "Confronted with a dying/dead body" included additional complicating actions. However, neither in that category nor in any other did I discern salient patterns correlating particular actions with each other.

Following are examples of each type of complicating action in which I analyze how an unreportable event becomes reportable. This process requires tracing a chain of events backwards, which involves additional summary statements about the narratives cited. Therefore, I cite only one representative example in each category.

Table 6.1: Categories and Types of Complicating Actions.

Complicating Action	Number in Corpus
Protocols: Procedures Provided	
Discussing code status/performing code	17
Making a mistake related to patients' death	13
Delivering bad news to patient, family	11
Pronouncing death of patient	11
Unexpected death of patient	4
Practice: Situations Encountered	
Confronted with dying /dead body	32
Confronted with medically futile situation	21
Experiencing death of relative	21
Experiencing patient death for first time	16
Experiencing death of trainee	7
Liminal: Foreign Setting	
Experiencing death in foreign country	14

Protocols as Complicating Actions (CA**)**

Results from analyzing 56 complicating actions relating to *protocols* physician-trainees are taught to manage patients at the end of life reveal not only the ineffectiveness of standardized procedures but the moral distress trainees experience when they rely upon what they see and hear, the detached concern informally taught. When interns, residents, and fellows fail to attend to the emotional weight of dying patients, they confront the powerlessness of medicine, the inadequacy of patient care as algorithm, and their own inadequacy as practitioners. Through narrative, however, the trainees create personal reflections that embody new perspectives on medical practice. They re-envision the expected in unexpected terms when they challenge institutional protocols: the truthfulness of resuscitation and what it really means for dying patients and physicians; the medical and educational significance of pronouncing the death of patients, for example. Trainees' versions contest medicine's rationality that values statistical

probability over patients' intuition; that reduces death to a medicalized problem and the management of physicians' resulting distress to a choice of "escape" strategies. Their narratives articulate medicine as a holistic practice, encompassing patients' emotions as well as their own. As physicians-in-training take into account the significance of patients' thoughts and feelings, they recognize the inextricable bounds between mind and body, which empowers them as moral individuals to care *for* nearly and newly dead patients.

Protocol #1

- Unreportable CA: *Discussing code status*
- Reportable Initial CA in "History" (Green, 2011): *Meaninglessness of medical procedures*

Ten of the 17 narratives in this category of complicating actions detail how physician-trainees attempted to or did discuss preferences for code status (do/do not resuscitate) with the patient; other narratives described trainees' performing codes. Representative of this category is "History" (Green, 2011), a tellable narrative because the trainee-author calls into question the meaningfulness of medical procedures that reduce the complexity of life especially for the dying into a choice of procedures. The 3rd-year resident is finishing her shift when she asks "a standard question I have been trained to include for all of my patients, though it still feels unnatural: *If your heart were to stop, would you want chest compressions, electric shocks, a breathing machine?"* (p. 1383; italics in original). What transforms this unreportable event is the patient's unexpected response: "'When it's my time to go, I'm ready,' she says, closing her eyes…trying not to cry. 'My husband died in April, two months short of our 50th

wedding anniversary,' she continues, her voice breaking. 'I miss him terribly'" (p. 1383). The procedures that the resident can offer—resuscitation, intubation, feeding tube--will not enable the patient to return to *her* life: "'I'm so sorry,' I say, and she thanks me, but we both know my words fall immeasurably short…I cannot make her whole again, cannot heal her infinite longing.'" Thus, the medical script for prolonging life is itself revealed as a code: symbolic questions physicians are trained to ask that gives providers as well as patients the false sense that medical procedures can revive patients and bring them back to the meaningful lives they have known.

Protocol #2

- Unreportable CA: *Making a medical mistake*
- Reportable Initial CA in "Trained to Avoid Primary Care" (Dowdy, 2011)*: Failure to acknowledge dying patient as influential person in medical career*

Making a medical mistake is the primary complicating action in 13 narratives. In this representative text, the resident's mistake—the complicating action that renders the sequence of events reportable—is his failure to acknowledge the humanity of his former patient in "Trained to Avoid Primary Care" (Dowdy, 2011). The resident depersonalizes the patient whose care he never followed up and who is now dead. In response to a social worker's e-mail request for names of the man's relatives to avoid "letting the county bury the body in an unmarked grave" (p. 776), the 2nd-year trainee quickly types--"no next of kin"--then finds himself crying. "I had chosen a career in medicine to dedicate myself to healing the lives of others, and before my training was complete, I was treating the end of a life as nothing more than e-mail 38, on another Tuesday night" (p. 776). Recognition of the relationship he shared with the dead man prompts "a mental memorial" for his patient

and a review of his 1st year of training. "I had begun residency in internal medicine convinced that I would pursue subspecialty fellowship. It was more about prestige than the money." His former patient, however, "taught me that I was a primary care physician at heart." Refusing medical intervention, the homeless man with metastatic bladder cancer and an aortic aneurysm placed a higher value on seeing his girlfriend and playing chess. "I learned that I needed to deal with a patient's social and psychological complexity to feel fulfilled." Thus, the resident challenges the medical model that empowers the physician by marginalizing the dying patient.

Protocol #3

- Unreportable CA: *Delivering bad news to patients; managing physicians' distress*
- Reportable CA in "Portraits" (Rowlett, 1990): *Ineffectiveness of standardized procedures to respond to all of human life*

Representative of the 11 narratives that describe physician-trainees delivering bad news to patients and/or their families is "Portraits" (Rowlett, 1990). It is a tellable narrative, because the physician-author realizes how the strategies he is trained to believe in and rely upon to deliver bad news to others, as well as to manage his own affective responses, do not prepare him for the vicissitudes of life; namely, the unexpected "rebirth of a human life" (p. 2798). The 3rd-year resident responds to a stat page to the emergency room for a 2-year-old boy who arrives in the same condition as a patient did during his 1st year of training. When that girl died, the resident was counseled by an attending physician to find a way to "'escape the hospital'" (p. 2798) and the "distress" of the death: "'You get better at dealing with them, but a child's death is always painful.'" The resident turns to outdoor photography, each picture he takes "a vivid reminder of a

shortened life" (p. 2798) that hangs on his bedroom wall. So when the now-experienced resident informs a new set of parents that their son will die, the trainee notes, "In the back of my mind I knew that tomorrow I would need to buy film before heading to the lake." The two linked events have become by this time a routine procedure. They become extraordinary when the boy lives through the night and then survives surgery and setbacks. When he is finally discharged, the resident gives the parents the photo he took the night he assumed the boy would die; "I told them I would explain later, and that I wanted [their son] Anthony to have it." The resident never explains. Instead, he creates a new "wall dedicated to the celebration of life" where he displays a picture the 2-year-old drew that his parents mailed to the resident.

Protocol #4

- Unreportable CA: *Pronouncing a patient dead*
- Reportable Initial CA in "Death Rituals" (Lerman, 2003): *Lack of medical recognition of the power of death*

Eleven narratives have as their complicating action physician-trainees certifying the death of a patient. In this example, "Death Rituals" (Lerman, 2003), the physician-author contests the ritual-like importance medicine attributes to procedures, notably declaring death, which reinforce the faulty perception of medicine's power. The narrative enables the physician-author, who also is a physician's daughter, to *pronounce* the subversive lesson she learned as a resident: to "claim small moments of reverence for death and the life it leaves behind" (p. 384).

As she watches a trainee declare her father dead, the physician recalls the first time she pronounced a patient 15 years earlier. It was "among my duties as a medical

intern" to which she was "summoned" (p. 384); a meaningless procedure to her, because "'He's dead. I have nothing to do for him. Doctors are here for life, not death." Nonetheless, she "fumbled" through the procedure, the same one the resident performs on her dead father: "laying a stethoscope on a nonrising chest, auscultating for heart sounds he knew he wouldn't hear, pulling back the closed eyelid and shining his penlight at the nonreactive pupil" (p. 384). The complicating action becomes reportable when the physician-daughter overlays the resident's pronouncement with her own existential responses, causing her to be "aggrieved for this new doctor": "This ritual had no power to convince me that my father was truly gone. It had nothing to teach Dr. Ernst [the trainee] of what death truly means." The power of pronouncing resides not with physicians but with death, which medical education does not honor, much less acknowledge.

Protocol #5

- Unreportable CA: *Experiencing an unexpected death*
- Reportable CA in "Seeing the Message" (Modi, 2006): *Medical statistics not accounting for patient's beliefs*

Four narratives have as the primary complicating action a physician-trainee experiencing the unexpected death of a patient. The representative narrative, "Seeing the Message" (Modi, 2006), brings into sight the power of emotions and the effect they can have on medical practice that relies upon the power of statistics. The narrative tells how the voice of one patient who "seems to have a message just for us" (p. 574) overrides "hundreds of others'" (un)expected deaths. A senior house officer relates the sequence of events that led to a patient's death following a coronary artery bypass. Before surgery,

the trainee is surprised to see the patient and the hospital priest in "deep discussion." The man "admitted that he was afraid of what lay ahead and feared that his operation would be less successful than he had been led to believe." Although the physician admits the patient was considered high risk, he says the patient "had been quoted a 20% mortality risk from the operation" (p. 574), which the trainee emphasizes in his conversation with the patient. When the man dies, the house officer is surprised—"The first I knew of this was the empty bed that faced me the next day"—although he knows death was not unexpected, given the patient's medical history. As the physician remarks, "the real surprise was not that one patient had weighed on my conscience but that hundreds of others had not." This realization makes the sequence of events reportable. The trainee did not expect that "our patients' beliefs are more important than anything we might be able to offer," which defies the rationality of medicine.

Practices as Complicating Actions

Results from the analysis of 97 complicating actions related to the *practice* of medicine reveal how physician-trainees' personal encounters with dying patients invalidate what they have been taught in the hidden curriculum. Trainees acknowledge the incomprehensibility of death, the way uninvited emotions toward the dying are manifest in their own bodies, causing them physical distress. Nor are trainees' minds, however disciplined, exempt from the effect of unruly emotions and the wiles of imagination. Fear associated with death and dying can generate horrific images that appear unbidden in nightmares as well as during trainees' hospital shifts, which negatively affect their behavior. What we see projected in these images—rows of dead

heads and feet; a resident's heart bleeding on a gurney--is the intimacy of medical practice that is silenced in the culture of medicine; the impossible detachment of trainees' most private and essential part of themselves: their body-mind-selves. When they come face to face with death, physicians-in-training discover that the best practice may not be a matter of clinical expertise but simply their presence as full human beings, in contradiction to the medical imperative and the insistence of medical technology.

Practice #1

- Unreportable CA: *Confronting dying/dead bodies*
- Initial Reportable CA in "A Bloody Day at the Accident and Emergency Department," (AlRubaiy, 2006): *Incomprehensibility of human violence*

Confronting dying/dead bodies, the most frequently occurring complicating action in the corpus, was identified in 32 narratives. Representative of this category is an account of senseless violence, "an everyday story" (AlRubaiy, 2006, p. 882) in the trainee-author's native Iraq, which she nonetheless is compelled to tell, because the story took place in Britain where she did not expect to experience such violence.

In "A Bloody Day at the Accident and Emergency Department," the author describes a mass casualty: "Blood was everywhere, and [the girls'] clean white school uniforms had turned crimson" (p. 882). The hospital ran out of beds and declared "a red emergency state." In and of itself, the scene was an ordinary one in an emergency room—"we were used to seeing casualties and lethal injuries"—although the magnitude was shocking—"80 schoolgirls at once." What "made me feel sick," reports the trainee, is her inability to fathom the cause: "I couldn't find any answer to the question of a why

a person would blow himself up to kill innocent schoolgirls." The complicating action, then, is the incomprehensibility of human violence worldwide.

Practice #2

- Unreportable CA: *Confronting medical futility*
- Reportable CA in "Gratitude, Memories, and Meaning in Medicine" (Bazari, 2010): *Bearing witness to patients' lives as a significant medical action*

Confronting a situation where medical treatment or intervention is futile is a complicating action in 21 of the corpus narratives. Representative is the narrative "Gratitude, Memories, and Meaning in Medicine" (Bazari, 2010), which is tellable for the subversive definition the physician-author proposes for how to meaningfully practice medicine at the end-of-life: to not *do* anything but "simply being present silently" (p. 2188).

A "thinking-of-you" card from the now-elderly daughter of a former patient, Mary, prompts the physician to recall Mary, the first hospital patient he admitted as an intern 26 years ago. He became her primary care physician until she died of metastatic gastric cancer. When he talks with the elderly daughter, however, he hears a forgotten sequence of events from his residency: "…when she was dying and you visited and sat with her while we went to lunch. We did not want her to be alone those last days of her life" (p. 2188). The complicating action is the physician's need, then and now, to find meaning in his career. As an intern, he had felt "unworthy of my post," his inexperience rendering his service of little or no value. As the director of a training program, he focuses on helping "navigating [trainees'] emotions during the development of a professional identity." Where the physician finds validation, he realizes, is in

acknowledging the power of patients by being with patients and their families "as they bear witness to the inevitable cycle of birth, life, illness, and death" (p. 2188); when he does nothing more as a physician than being present as a fully feeling human being.

Practice #3

- Unreportable CA: *Experiencing the death of a relative*
- Reportable CA in "Thank You All for Coming" (Taylor, 2004): *Disabling the coping mechanism of emotional detachment*

Trainees experienced the death of a relative in 21 narratives. Representative of this complicating action is "Thank You All for Coming" (Taylor, 2004), in which the physician-author tells how she is put to her final test--"Will I be able to handle the immense responsibility of caring for dying patients?" (p. 547)--when her grandmother is dying. No longer can she rely on the strategy of "mental disconnect." She answers her own question, expected by many residents, by living her response, which she does not expect and therefore makes the narrative tellable.

When her grandmother "became gravely ill" and her family acceded to her as "the expert," the trainee has a recurring nightmare from medical school: "I had to do a rotation on the death ward," which housed "a huge freezer" with "rows and rows of heads and feet—dead people lying down" (p. 547). She flees to another room "with very sick, very old people sleeping. Some of them were in large plastic garment bags….A tall female doctor in a long white coat was working there. She was envious of me that I could leave and she could not." Now, the physician recognizes the doctor in her dream as "me at the end of my training" (p. 548), which renews her insecurity. What makes her anxiety reportable is that the recurring nightmare disallows her usual coping mechanism; she

"connects" with her dying grandmother, proving to herself that she can care for the dying even when "[a]nxious and afraid."

Practice #4

- Unreportable CA: *Experiencing patient death for the first time*
- Reportable CA in "Death in Primary Care" (Sommers, 2011): *Death as validation and reaffirmation of a career in medicine*

Representative of the 16 narratives in which the complicating action is a trainee's first experience of a patient's death is "Death in Primary Care" (Sommers, 2011). Not only does the sudden death of an elderly woman the physician-trainee cares for at an outpatient clinic prompt him to review their relationship; it also enables him to articulate and validate his decision to pursue primary care medicine.

The death of Mrs. Smith, an 81-year-old woman whom the physician-author sees monthly in clinic for multiple chronic medical problems, is literally not the first he has experienced. "As a third-year resident, I'd taken care of more than a dozen patients who died in the hospital" (p. 457). Mrs. Smith, however, is "the first whom I considered truly *my* patient" (emphasis in original). Reflecting upon their 2-year relationship, which included the patient's adult daughter, the resident names "two additional emotions I hadn't experienced…Nostalgia. And a deep sense of loss" after she died. The resident realizes that Mrs. Smith's death "crystallized for me the difference between inpatient medicine and primary care": "the unique bond that primary care creates between the doctor, patient, and the patient's family. It is a relationship like no other in medicine." What makes the narrative reportable is how death, often equated with failure in the culture of medicine, enables the trainee-author to reaffirm his decision to become a primary care physician. Death affirms his goal in life.

Practice #5

- Unreportable CA: *Experiencing the death of a trainee*
- Reportable CA in "What I Have Seen" (Transue, 2003): *Owning grief validates the death of another and the life of the narrator*

At a large Seattle teaching hospital, the physician-author of "What I Have Seen" (Transue, 2003) reports the event she does *not* see—the body of her dying friend—so her own grief will not go unreported and become "ordinary." Her narrative represents the other six in in the corpus in which the complicating action is a postgraduate's first experience with the death of another trainee. The author argues for an embodied understanding of death, for physicians to physically experience their own affective responses to another's death.

As a trainee, the author says she has witnessed "griefs (and countless joys) play out there every day: I've worked there, I've seen enough." By "enough," she means "many things in the rooms of the ICU at Hillside that no one should ever have to see. I saw a man vomit up all of the blood in his body and the 20 additional units I gave him besides, not dying until every surface in the room had been painted red with his blood…." When she tells a mutual physician-friend that she wants to visit their friend who suffered a brain trauma associated with an accidental fall, however, he cautions the author not to: "the truth was that [Anabel] didn't look too good right now: 'You know, you've seen these things…'" (p. 2620). The event that the resident-author is compelled to tell is what she does *not* see: "I have never seen a piece of my own heart bleeding on one of these gurneys. I have never see Anabel in a bed at Hillside outside a call room." The two women had met on the first day of their internship in Seattle and their friendship flourished. While the resident knows "that my own searing grief is commonplace," it is

also “unthinkable” that, as a physician, she would ever become inured to such deep emotion or death. To ignore her emotions is to extirpate her own heart.

Liminal Complicating Actions

The complicating actions found in 14 narratives of cross-cultural encounters with dying patients bring into view medicine as a social practice, contingent less on science than on wealth, status, geography, and fortune at birth. Western-educated residents, proficient in using advanced medical technology, are beset with end-of-life situations for which their training has not prepared them: the injustice and inequity of medical care, the horror of mass casualties, and the restrictions of cultural taboos, all of which make the physician-trainees’ narratives tellable. What the chain of complicating actions reveals is the practice of medicine at its fundamental level: a human practice of caring, sometimes more, rarely less.

Seven of the trainees’ accounts of medical missions and international residencies are set in African countries--Ethiopia, Malawi (2), Kenya (2), and Angola—where electricity and clean water are not always available. Other narratives take place in Afghanistan, Viet Nam, Korea, Saudi Arabia, and the Amazon rain forest. Two additional narratives take place in developed countries, but their rural locations render them more like underdeveloped countries: a native community in British Columbia, Canada, and a village in the Alps of Switzerland. In all of these settings, trainees are situated in the space between cultures where they encounter unprecedented experiences with death. The following is representative of the complicating actions in this category.

Liminal

- Unreportable CA: *Experiencing death in an Other country*
- Reportable CA in "Doing What We Can with What We Have" (Lowe & Lowe, 2008): *Medical care contingent on social, political, cultural conditions*

An emergency medicine resident and his pediatric resident wife worked for one month at an Ethiopian hospital, where they learn as never before "how to do what we could, with what we had, for whom we could" (Lowe & Lowe, 2008, p. 328). Health is not the product of medical practice so much as what is allowable by the social constraints of politics, economics, and culture.

The couple tells of a particularly difficult early encounter with death. Within minutes after examining a young woman with HIV and a respiratory infection, they watch as she unexpectedly begins actively dying. Her family was led away and told by the nurse "'she is fine'" (p. 328). The American residents "found that the one tool we had to offer in this case, comforting words and support, was not available to us" (p. 328), because they had "to obey cultural norms that we didn't understand and in which we didn't necessarily believe" (p. 329). After the patient's family leaves, the Ethiopian senior physician tells the emergency medicine resident to stop resuscitation efforts. The American is not surprised, since the "recycled bag-valve-mask" delivered only "ambient air." But when the foreign doctor remarks that, even if a ventilator were available, the patient's family could not afford to pay for its use, the resident is deeply distressed. "I have been faced with irreversible situations, but it was something new to admit that we had reached our boundary when it was purely resource scarcity limiting the care of someone so young with a process that *could* have been reversible" (p. 329). His moral

distress is compounded by the silence forced upon him and his wife by an unfamiliar culture.

Evaluation as Expressions of (Inexpressible) Emotions and Cognition

Findings from the analysis of *evaluation* show how extensive the impact of physician-trainees' problematic encounters with dying and death is; their discursive responses attest to personal and professional repercussions beyond postgraduate education extending throughout their lives. Words and phrases that comment on the emotional and psychological, existential and ontological, professional and social dimensions of end-of-life care reveal the magnitude of death as trainees voice their affective and experiential responses. Trainees express uncertainty when attending to dying patients, asking unanswerable questions that challenge how they have been enculturated to think and to speak as practitioners of medicine as an applied science. As a result, their narratives serve as counter-narratives to medicine's hidden curriculum; their rhetorical strategies disclose reasons why trainees resist and subvert institutional teachings.

Evaluation has been called "the most important element in in addition to the basic narrative clause" (Labov, 2009, p. 222), because it entails "stating or underscoring what is interesting or unusual about the story, why the audience should keep listening and the teller to keep telling" (Johnstone, 2008, p. 93). Evaluations are often distributed throughout the narrative, creating another level of tension that impel readers to finish the story so as to understand its significance. To categorize evaluations in the study corpus, I adapted Martha Shiro's example, as noted in Chapter 3. She examined "feelings,

thoughts, and speech as a way of approaching narrative evaluation" (2003, p. 171) of children by focusing on evaluative expressions of emotions, cognition, perception, and physical states. I revised her categories to more accurately reflect the nature of evaluative expressions in medicine and to help reveal reasons why trainees tell their narratives. I developed three types of evaluations that I used to analyze the study corpus--emotional/psychological, existential/ontological, and professional/social evaluations—which I define below. I provide examples of the three types of evaluations, prefacing each set with a summary of findings, and then follow with a statement about the narrative from which the quotes have been excerpted. I add italics to highlight words that comprise the core evaluation.

I have not tabulated results from my analysis of evaluative expressions as I have with the analyses of other narrative elements, since the frequency of evaluation expressions is not as significant to my research question as the actual inclusion of evaluations. In all 120 personal narratives in the study corpus, I found at least one example of each of the three types of evaluation expressions, in some narratives, as many as 10. I did examine the frequency and distribution of evaluations to see whether there were any correlations between these numbers and the 11 types of complicating actions I identified, but I did not discern any patterns or salient relationships.

Emotional/Psychological Evaluations

Physician-trainees' evaluations show a heightened self-awareness of their own emotional and psychological states as well as sensitivity to those of others. Their evaluations of encounters with dying patients blur the lines that medical professionalism

draws, revealing how bodies decomposing through disease reflect a new composite view of humanity: an affective recomposition. The dying body recomposes medicine's perception of the relationship of mind versus body from opposition to reciprocity; emotions and cognition are experienced in the body, just as the body gives rise to emotions and psychological states. Through narrative, physicians *attend* to their bodies as well as those of patients.

In the following excerpts, I italicize emotive words and phrases that comprise the core emotional/psychological evaluation; language that significantly differs in register from the discourse of the medical journal in which the excerpt appears.

Examples

In "Beyond Hope?" (Srivastava, 2002), a medical registrar returns to a rural Australian hospital where she meets a former patient, a young man to whom she had given "a death sentence" (p. 1204) the previous year following a heroin overdose and coma. Her evaluations focus primarily on her own psychological states and emotions and some she claims to share with the patient and his mother (p. 1204):

- "I was reluctant to let *ghosts of the past to resurface*."
- "*Tears flow freely* as we confront the miracle before us. Together, we had seen much *vulnerability mingled with fear, love linked inextricably with grief*."
- "…I am *overcome with immeasurable gratitude for the courage* I have witnessed."

In the second set of examples, a young woman finds herself fulfilling dual roles as

daughter and physician in "The Space Between" (Duffy, 2009); her father is diagnosed with lung cancer and relies upon her medical advice. The resident's evaluations center on her own emotions, although she explicitly comments on the difficulty all physicians have separating themselves emotionally from ill family members (p. S429):

- "I was *touched by his faith in* me, but *terrified* because it reflected how *frightened my father was* by what was happening to him."
- "…it is easy to *conceal* its true meaning out of *your own fears and desires*. The health professional who *loses a loved* one to cancer is, themselves, a sort of cancer survivor."
- "I *still struggle* to ensure I separate *my own wants, fears, and desires* from those of *my loved one*."

In "Joshua Knew" (Clark, 1993), a 5-year-old boy with AIDS unexpectedly announces to his physician that he is ready to die in the hospital. The resident tells the father and then watches both parents with their son. In addition to evaluating her own emotions, she attributes feelings to the boy's parents, using emotionally laden phrases to describe their actions (p. 2902):

- "As I left the room, I *struggled to regain control of my emotions*. I had felt *so helpless*…"
- "He approached me, *searching my face* for *some sign of hope*."
- "They *murmured softly*, telling him *how much they loved him*."

The dependent clause in the second statement above--"searching my face"--points to a critical aspect of physician-trainees' evaluations: Emotions are not only conveyed and expressed to others through the body; they are experienced in the body. Hope is an

abstract feeling, but it becomes visually perceptible when it is felt in the trainee's body. Other trainee-authors recount a similar awareness of emotions experienced in their own bodies:

- "*In my tension* I had been *clenching my toes* inside my shoes the whole time" (Glazer, 2004, p. 610).
- "*My heart is in my throat* from both her cries and *my own surge* of emotions" (Rifkin, 1997, p. 373).
- "As [the mother of the pediatric patient] cries, she runs the fingers of her right hand *nervously* through her husband's hair near the nape of his neck. This small act seems to calm her a little. I *flinch* as I watch this, as I too seek this gesture with my husband *when I am upset*" (Moreno, 2003, p. 956)

Emotional/psychological evaluations presume the corporeality of the bodies not only of patients and family members, but of physicians. Their bodies, like those of patients they attend to, remind them of their own mortality and the vulnerability they share with patients as fellow human beings. As a geriatrics fellow comments in "On Deeper Reflection" (Sachs, 1988) after seeing himself mirrored in the metal head of a patient's hip prosthesis: "It is a sharp reminder that I am always inside patients like Mrs. Smith and that they are always inside me; all of us are part of the human community, no matter how demented, contracted, or incontinent" (p. 2145).

Existential/Ontological Evaluations

Analysis of existential/ontological evaluations demonstrates that resident-authors experience cognitive tension *being* physicians; assuming their place in the world as

physicians whose professional mode of being sets them apart from patients. Ways of knowing that are valued, taught, and modeled in medicine as an applied science—impartial observation of truths visible and verifiable—are challenged by trainees' actual experiences with dying patients, which raise philosophical quandaries about human existence. For many, death threatens the rational thinking that girds the institution of medicine and assures the certainty of knowing, resulting in physicians' discomfort attending to dying patients. As the examples show, trainees are not yet fully enculturated; they are in the process of developing the behaviors and thoughts that will distinguish them as physicians. From this liminal position, they can resist and even subvert what they have been taught about how to *be* a physician.

By *existential*, I mean evaluative comments physician-authors make regarding how they understand, or attempt to, their existence as human beings. The evaluations do not reference any particular philosophical theory, namely, existentialism. Similarly, I use *ontological* to refer to the nature of physician-authors as physical bodies; the corporeality or materiality of their *being* human. Ontological evaluations do not relate to any overarching theory of metaphysics.

As with emotional/psychological evaluations, I italicize words and phrases in the excerpts below that comprise the core existential/ontological evaluative expressions to emphasize how the language of evaluations contrasts with the surrounding discourse.

Examples

Although anxious and uneasy about discussions of death, a resident in obstetrics and gynecology expects neither replies nor answers to existential questions. She accepts

the uncertainty of not knowing, a nonmedical approach represented by her grammatical choice to frame evaluations regarding a dead baby as rhetorical questions in "Reflection on Death" (Newlands, 2011, p. 1072):

- "*Not that I worried about the end of life*, *the physical act or the body*; no, I was concerned about *how I would answer the unanswerable questions surrounding death*…"
- "*Do you call it a baby or a fetus or a child? Do the semantics matter*?"
- "Her tiny formed fingers, curled up *as if grasping for something. Life?*"

In contrast, a resident working at a hospital in Malawi in "Meeting Death" (Laux, 2012) uses declarative sentences when making many of his evaluative comments. He looks to rationality and the logic of cause-effect thinking to help him understand how "natural" death is "one of the most un-natural things a person can witness" (p. 741). He criticizes Christianity's explanation of death that he believes favors those living in developed countries.

- "*Dying is a brutal thing*—tinged, tainted, marinated in the dregs of injustice."
- "In her case, I wanted to peg this series of unfortunate events on something—a character defect, or readily available wrong…*There was no clear cause, fair or unfair*, that I could callously press onto her gaunt, emaciated frame."
- "What a luxury to process the emotions of a loved one's death, *to find an order, or maybe even a meaning, in every event.* We say, 'God called them home,' never stopping to think that God seems to have a predilection for filling heaven with the younger, darker, poorer members of the human race" (p. 742)

The resident overlays existential/ontological evaluations with emotional/psychological expressions—for example, "Dying is a *brutal* thing—*tinged, tainted, marinated in the dregs* of injustice" (italics added)—which suggests his own inability to separate cognitive processes from his personal emotions as he has been trained to do. Also, the resident refers to dying not as a process but a *thing*, an object: a conception problematized in the next example.

In "Caring for Mr. Gray" (McMurray, 2000), a physician is emotional as she recounts a mistake made during her residency 20 years ago, the memory "a searing, scorching pain for which there is no remedy" (p. 144). She had dismissed a patient's report of difficulty breathing as depression; he died 3 days later from a ruptured heart valve. Like her, the patient was a Southerner living in New York City, "a bright spark" (p. 145) who understood her criticisms of the foreign urban culture that challenged her notions of existence.

- "Staring at the addict's arms long and hard, she *puzzled* over their track marks, her *wry awareness of her naiveté* submerged under *a sense of vibrant life*, her joy in *her anonymity and independence*, her wonder at *this out of control mass of humanity of which she was now a part*" (p. 144).
- "The resident stopped by to say somewhat brusquely, '*It just happened. Life goes on*,' as she sank down behind the counter" (p. 145).
- "*Rocked to the core*, there seemed *no certainty to life*, only the *certitude of death*, and failure on her part" (p. 146).

Her patient's death brought to life the meaning of abstract concepts; his dead body personified life and death in a way medical education had not prepared her for: "his

memory was for her the marker of her real initiation into life and inevitable death" (p. 146). Riding on the city train, she had relished "anonymity and independence." Yet in the hospital, where her patient's death is rendered anonymous by fellow residents—"'It just happened.'"--her world view is thrown off center. She had celebrated feeling part of "this out of control mass of humanity," yet the intern cannot perceive his death as an instance of her own human inability to control life; even 20 years later, the physician writes, "it had to have been a mistake" (p. 144). Not only was the author disoriented geographically as an intern; she remains culturally disoriented, still struggling to reconcile how she can exist in the world as a physician and a human being.

The third set of examples of existential/ontological evaluations is from "Into the Spirit World" (Lodge, 2010), which also contrasts urban and rural medical cultures while interrogating existential and ontological questions. A family medicine resident on call at a small hospital in rural British Columbia takes over the palliative care of "an aboriginal guy" with heart problems. He had had a defibrillator implanted but "hadn't understood" the procedure at the city hospital due to the "[s]ame old communication barriers" (p. 56). The defibrillator malfunctions, challenging the trainee's ability to help the man die in accordance with his traditional beliefs: peacefully, not "eyes filled with terror" that he would "be shocked back to life when he died."

- "The moon shone pale and full, and a faint breeze rustled through the trees. I looked down the lane…it was always *a strange sensation stepping out into the dark* alley" (p. 56).
- "'*I am ready to go to the spirit world*,' he replied. 'I have been ready for a while now'" (p. 56)

- "As the sun came up over the mountain ridge, I drove hard down one of the logging roads that carved a path out of town into the mountain range. *My body felt electric*'" (p. 57).
- "There was a spirit dance two days later. *A second time, I watched as he passed into the spirit world*" (p. 57).

The family medicine resident is consciously aware of different levels of existence: He is "stepping out into" an unfamiliar landscape at the rural hospital; his body feels "strange" in the presence of the natural world, the wilderness. Awareness of his own corporeality brings to mind his physical vulnerability: "I was pretty sure that marauding bears were not a problem for most of [my medical school classmates]" (pp. 56-57). He also is increasingly aware of life's metaphysical level, most evident when his evaluations acknowledge the "spirit world" of his patient whose stories "were wonderful and full of feeling and humour [cq]" (p. 56). That the trainee describes the patient as "an aboriginal guy," rather than a native, is significant, for *aboriginal* refers to a region's "earliest known inhabitants" (*Webster's New World Dictionary*), giving symbolic or mythic weight to the meaning of the patient's stories, his life, and particularly, his death. The man wants to die: a natural choice according to his traditions. To continue living with the defibrillator would artificially extend his life; it would be unnatural.

Thus, the resident's narrative calls into question the nature and role of metaphysics, a world view outside scientific thinking, since metaphysical truth is not the result of objective knowledge. The trainee suggests that the materiality of the human body can be incorporated into metaphysics and metaphysics into medicine. When he is challenged as a physician to figure out how to deactivate the patient's defibrillator, he

consults a cardiology fellow by long-distance phone who says only a magnet can perform that function. So the resident finds and places a small magnet on the patient's chest. The device ceases, and the patient soon is deceased. The trainee essentially reverses medicalization: he inactivates the (faulty) technological solution to the medical problem of how to (unnaturally) sustain life, thereby metaphysically reviving the patient who can now "go to the spirit world." He has also revived himself: "My body felt electric." The physician is excited, charged with life—but only through helping the patient to die.

This reverse narrative recounts a subversive practice of medicine that undermines its scientific basis. Although not representative of all trainees' world views, the metaphysical stance presented in the narrative is significant, because it show how physician-trainees create narratives that counter those of the institution of medicine. The trainee's narrative is about the metaphysical practice of medicine that is not part of medical education or training.

Professional/Social Evaluations

Through professional/social evaluations, physician-trainees subversively cede power to patients as well as empower themselves as postgraduates, remodeling dynamics of the traditional doctor-patient relationship and reversing tenets of the informal curriculum. Physician-trainees call out deficiencies in the culture of medicine by criticizing those higher on the hierarchy of medical training and then holding them accountable for modeling unprofessional practices. Trainees' evaluative expressions on the social standing of patients further upset the medical hierarchy. When residents

recognize the vulnerability of dying patients and see in them attributes of the living, they challenge the lack of humanity modeled by some attending physicians.

Examples

In "Terminal Careless" (*BMJ*, 1989), the anonymous physician-author reflects on what she considers her own lack professionalism and that of other medical colleagues attending to her dying father (p. 1471):

- "Despite the best of intentions the junior houseman had neither the required knowledge, experience, or authority to cope."
- "I, his doctor daughter, failed to claim adequate care and analgesia for him."
- "The general practitioner also failed…to consider that the symptoms might be genuine. And later he failed to give a man with a definite disseminated carcinomatosis adequate and appropriate analgesia."
- "Finally, the hospital failed…it lacked a system to ensure its proper administration."

The physician tells her narrative to "make a plea for improvement"; "I worry for the future of our NHS where these improvements might not be economically desirable." She wants to bring awareness to a system-wide lack of professionalism in end-of-life care. In addition to these rational reasons, however, she is compelled emotionally to convey her personal experiences: "I cry. I cry for my father. I cry for my own part in this." Furthermore, the physician wants to speak for the dead who have no voice and no power: "After all, the dead and dying can have little influence on market forces." Thus, she critically comments on the lack of recognition given to the dying; once deemed terminal,

patients are denied authority. Her decision to remain anonymous, however—she does not sign her article--could be argued to negate her efforts.

The intern-author of "Lessons from East Africa" (Cook, 2010) focuses her negative evaluative comments on the unjust international practice of medicine. She uses emotionally laden language when describing situations and events that renders them social criticisms.

- "…I never envisioned the lack of the fundamental such as IV fluids or pain medications. I wanted to believe that the lack of tools in resource-limited areas of the world could be made up for by keen diagnostic skills and years of experience." (p. 393)
- "Startled back to the reality here: this stifling ward packed with sick and dying patients, mosquito nets strung above each bed and family members squeezed into the space between beds, lying or sitting on the grimy linoleum floor."
- "…within minutes, the nurses covered the [deceased] patient with a wrinkled white sheet and wheeled away the squeaky, rusty bed to make room for the next of many patients lined up in the hallway."
- "…I became more disturbed about the lack of hospital funds for basic medical supplies. My stomach churned as I read about the corruption in the country's government and its role in hospital funding."

Her evaluations are forceful in part because of her vivid descriptions—"stifling ward"; "the grimy linoleum floor"--and the powerful use of pathos: "covered the patient with a wrinkled white sheet and wheeled away the squeaky, rusty bed." Even those unfamiliar

with East Africa can see how the delivery of health care is impacted by social and political conditions. Particularly significant is a clause in the final evaluation above—"My stomach churned…"—for it tells how the intangible concepts of injustice and corruption that affect patients and their care are experienced viscerally by physicians. While *social* criticism is made at an institutional or cultural level, it is felt at the level of individual bodies. Thus, the trainee's evaluation shows how emotion, perception, and cognition are inextricably bound to physical states of being.

The final set of examples are taken from "The Legacy" (Cozart, 1993), set in an American hospital where the physician-author recounts his experience as a story. He describes settings and characters; shows characters in action; and provides direct dialogue, so that we "hear" characters speaking. As a result, evaluative expressions take different forms than in previous narratives; they exemplify traditional forms cited by Labov and Johnstone.[47] Evaluative comments about physicians' professionalism, or lack of, are attributed to Phil, a 19-year-old dying of acute lymphocytic leukemia. They also are included as details embedded in the narrative and are suggested by other characters' actions and gestures (p. 1160):

- "'My last doctor was a real jerk, and I bet you will be, too!' That concluded my first conversation with Phil."
- "A sign posted over his bed read: 'CAUTION—DAY SLEEPER!' I shook Phil awake and quickly realized I had made a mistake."

[47]These include comments on the story made from the outside as if by an omniscient narrator; comments attributed to characters in the story; "intensifiers" such as gestures; "'correlatives' that tell what was occurring simultaneously"; and "'explicatives' that are appended to narrative or evaluative clauses" (Johnstone, 2008, p. 93).

- “I noticed the sign above his bed had been amended: ‘INTERNS WILL BE SHOT ON SIGHT!’”
- “’What did you say?’ the attending demanded. In response, Phil flipped a switch on his enormous boom box: ‘Highway to Hell’ by AC/DC screeched at full volume. As Phil started to sing along, the attending’s face turned beet red with anger, and I struggled to stifle my laughter.”

Social evaluations are made through descriptions of Phil and emotional and psychological states that the author attributes to the patient. As noted in previous examples, evaluative categories can overlap; the third and fourth excerpts below also could be identified as existential evaluative expressions (p. 1160):

- “Phil really came alive at night. Dressed in his favorite Guns n’ Roses T-shirt and armed with a high-powered water gun shaped like an M-16, Phil terrorized the nurses.”
- "'Before this leukemia got me down, I used to ride a Harley and party all night,’ he told me. ‘I could drink a six-pack of beer in less than three minutes.'"
- “Beneath that outrageous, exasperating exterior was just a scared boy, alone, afraid of dying.”
- “He liked to play his radio loud, close his eyes, and strum along on his guitar. I think he must have imagined himself on-stage, before a huge audience, in a world far away from sickness and disease. I wanted to give him that world, to make sure that he never came back to mine.”

Although the evaluative expressions are indirect, the intern-author's critique of medical practice and the way in which it is modeled in training is clear: It is laughable at times—"the attending's face turned beet red with anger, and I struggled to stifle my laughter." However, laughter does not mean only funny; it also connotes contempt or scorn. By attributing negative perceptions of medicine to a patient—"My last doctor was a jerk"—the intern can express his own contempt for doctors who fail to respect patients, yet he can do so from a protected space. The intern cannot be held accountable for the patient's choice of words. Moreover, through his telling, the trainee not only resists the power dynamics of the traditional doctor-patient relationship he sees being modeled but inverts it. The intern-author visits Phil at night when the patient prefers and listens to music with him: he empowers the teenager as much as he can within the confines of his hospital room. When Phil is discharged from the hospital, he bequeaths his water gun to the intern: "'It worked real well on you—got you in shape. Why don't I just leave it with you, so you can blast the nurses if they get out of line?'" Instead, the intern hands it to a newly admitted 8-year-old boy whose cries—"'I *hate* it here!'"--are stalling his chemotherapy. Thus, the intern not only arms the patient against the institution of medicine; he arms fellow trainees as he remodels patient care by telling others through narrative.

Therefore, I contend that the oppositional narratives published in medical journals provide vital knowledge for physicians that instruct them how to *be* physicians. The narratives serve as "a social pedagogy" (Frank, 2005, p. xiii); "a pedagogy in narrative" that conveys a range of possible narrative identities. Physicians' personal narratives are, to use the terminology of narrative psychologist Jerome Bruner, "'subjunctive' stories'"

that "can be tried on for psychological size, accepted if they fit, rejected if they pinch identity" (1990, p. 54); stories "trafficking in human possibilities rather than in settled certainties" (Bruner, 1986, p. 26). Unlike a majority of discourse published in medical journals, personal narratives are not "governed" by "empirical verification and logical requiredness" (Bruner, 1990, p. 4). Accordingly, physicians' personal narratives are "viable instruments for social negotiation" (p. 55) in the culture of medicine.

Final Passages: *Codas* as Challenges to Clinical Time

Physician-authors use codas much like metadiscourse discussed in Chapter 5--to tell readers how to understand, to interpret the significance of their narratives—but with two critical differences. Whereas metadiscourse permits the author to interrupt the discourse to insert her authority, a coda *is* the voice of the author, a first-person account in which the individual physician has authority throughout--and the final word. Findings from my narrative analysis of codas, the final words of a text, reveal how trainees strategically use codas to tell how they resolved moral conflicts relating to death by resisting the hidden curriculum. They reposition themselves in time, moving away from medicine's restricted linear chronology into a reflexive understanding of time afforded by narrative. From a retrospective stance, trainees reconsider death not as a moment of medical failure but as an opportunity to recall what they did not comprehend at the time: how it felt coming face to face with a dying patient, what the experience of dying meant for that person as well as their own self personally and professionally. Narrative affords physicians the time to make connections with others and their selves, thereby challenging cultural narratives of physicians' professional development as individuals set apart from

others. Codas, I argue, are key narrative elements that reveal how physician-authors resist the hidden curriculum by challenging the taken-for-granted institutional conception of time and death, which then allows them to narratively compose their own subjectivity.

Time in the hospital culture where interns and residents are trained is viewed "through the lens of the passage of time" (Kaufman, 2005, p. 7); time is valued in terms of "economic and clinical efficiency" measured by clinical tasks: "things health professionals think should happen and for things that must get done" (p. 7).[48] Time has been called "a valuable diagnostic tool" (Hall, 2000, p. 22), though poorly understood and used. Dying in particular elicits rapid deployment of the medical imperative: "to stave off death with the most sophisticated technological means available" (Kaufman, 2005, p. 25). Physicians routinely rely upon cardiopulmonary resuscitation, mechanical ventilation, and artificial nutrition, which not only prolong patients' lives but also sustain the medicalized conception of time as forward-looking and controllable.

This progressive, linear understanding of time follows from what has been referred to as the "logio-scientific" or "paradigmatic" (Bruner, 1986, p. 13) mode of thought used in mathematics and science where the goal is to convince others of universal, objective truths. In contrast, narrative psychologist Jerome Bruner posits the "imaginative" or "narrative mode" of thought. When understanding stories of life experience, "verisimilitude" (p. 11) is more important than logical truth, for "psychic reality dominates" (p. 14) narratives of the human condition. What is needed, argues

[48] In discussing the conceptualization of time in medicine, physicians (Krakauer 1996; Hall 2000) have traced "serial time" to the 15th century and the invention of the clock, which drew people's attention to the passage of time. "The ways in which a person made use of time became the barometer of a good or successful life" (Hall, 2000, p. 20). In a similar way, physicians are trained to make the best use of limited time.

Bruner, is imagination defined as "the ability to see possible formal connections before one is able to prove them" (p. 13).

Foremost among theorists examining the connections between narrative, time, and identity was Paul Ricoeur, discussed in Chapter 2. In his later essays, the French philosopher aimed "to rethink" how narrative "contributes to making life, in the biological sense of the word, a human life" (Ricoeur, 1991a, p. 20) by proposing the concept of "narrative identity" (Ricoeur, 1991b, p. 188). The connections or relationships he articulates are not only evident in findings from my narrative analysis of codas; they support my argument that through narrative, physician-authors reconceptualize time and their self-identity. How they do so can be discerned through Ricoeur's notions of plot and emplotment, discordance and concordance, configuration, deep time, and narrative identity, which I discuss in relation to the analysis of exemplar codas that follow. Briefly, *plot* means for Ricoeur "an integrating process" (1991a, p. 21), which is very similar to *emplotment,* "a synthesis of heterogeneous elements" by which he means bringing together from memory the multiple events that constitute a unified story. Thus, a narrative is simultaneously *discordant*—the events are multiple as well as expected and unexpected--and *concordant*—the events nonetheless come together to compose the story and bring it to a conclusion (p. 22). *Concordance* always dominates, though narrative depends upon its struggle with *discordance*. *Configuration* refers to the "process of composition" (p. 26); "the integration, culmination and closure" (p. 22) of events in time that follows emplotment. Here, Ricoeur intends time in a "profound" (p. 22) sense; a "deeper experience of time" (1980, p. 165) than "a chronology of sequence." Narrative time is "the deep *unity* of future, past, and present,"

which he also defines as "coming forth, having been, and making present" (pp. 176-177) that we come to through recollection. Memory, according to Ricoeur, is not "the narrative of external adventures stretching along episodic time. It is itself the spiral movement that…brings us back to the almost motionless constellation of potentialities that narrative retrieves" (1980, p. 182). Thus, narrative's deep time opens up possibilities for personal identity that "escapes the apparent choice between sheer change and absolute identity" (1991a, p. 33). *Narrative identity* emerges from the tension that arises between *discordance* and *concordance* as humans configure plots given to them by culture with those individually discovered; they compose a subjectivity or personal identity that is and always will be dynamic.

Below are three representative codas from the study corpus. I identify how each exemplifies one or more functions of a coda as defined by Labov (1972): describing the effect of narrative events on the narrator; connecting the past events of the narrative to the present world; and/or making general observations. I then elaborate upon each coda in terms of Ricoeur's narrative theory to show how physician-authors turn to a different conception of time, which enables them to resist the hidden curriculum and compose a new personal identity.

Coda #1—Discordant and Concordant Events in Life

"I never see [the dying infant's parents] again."

This single-line final paragraph is the coda to "A Father's Eyes" (Schultz, 1994, p. 1146; italics added above), albeit a reverse or negative image of what a coda usually does: It severs any connection between past events of the narrative and the present world

of the physician-author; it erases any relationship between the former intern and the parents. But the absolute certainty of "never" belies the impossibility of the author's claim that he can blind himself to what he saw: discordant images of himself as a physician incapacitated by fear, grief, and love whose truth he knows from his own experience as a father. This is what he cannot, as a physician-in-training, allow himself to remember: how his two conflicting *I's*, his disparate professional and personal selves came into focus in the eyes of the father to form a subjectivity whose pain and powerlessness he does not want to, yet cannot help but remember. Thus, I maintain that the coda does return our focus to what the intern saw in "A Father's Eyes," connecting discordant events to form a narrative from his life that redefines his self as a physician.

During his first year of residency, the trainee encounters the father of a dying infant who, seemingly oblivious to the situation, asks, "'Will he live…please, what has happened to my son?'" (p. 1146). The trainee is aware of his own complicated reactions: professionally, "I don't know what to say, and very quickly I am unable to say anything"; existentially, "the fears of my own son's mortality" flash by; and emotionally, "Grief rises into my throat. 'I…excuse me,' is all I can say, and before I can even get out the door the tears start." The intern ends the narrative by describing events that resolve the plot's tension: "My beeper goes off. I wipe my face, blow my nose. I don't go back into the room, and I don't leave a note" (p. 1146).

Although the intern never physically *sees* the parents again, he does repeatedly re-envision them in his mind: when he reflects on the events that constitute his experience, as he (re)composes the narrative from these memories, and then, as he discursively

restates what happened. And when he reimagines the parents, the trainee remembers what he saw reflected in the father's eyes:

> Images of my own son fill my mind: the toothless grins and sweet breast-milk breath as a baby, the squeals of laughter of a mischievous toddler, the warmth of his sleeping body nestled in my protecting arms, the innocent questions that challenge me, make me pause, make me smile….the love. And through it all, the fierce desire to protect him, to allow him to explore, but to shelter him from all harm. The love. (p. 1146)

While the vital images of his son are indeed the reverse images of the dying infant in the hospital, the physician-author integrates the discordant images through recollection. He discovers the part of his story that endures even the silencing of professional medicine: the power of love, the single and strongest emotion that gives meaning to our lives. Although love cannot prevent death, it nonetheless defies death when it is not medicalized as failure and bounded by measurable clinical time. When it is embodied and fully experienced, love gives meaning to death as well as to life. In this resident's narrative, as in a majority of those in the study corpus, we see the primacy of concordance enacted: how the emotion, the love, the trainee has experienced in his own life, through his own body, supersedes the model of the rational, detached physician promulgated by the hidden curriculum. What "remains across that which passes and flows away" (Ricoeur, 1991a, p. 22) is not the cultural narrative given to physician-trainees, a sequential story of professional development that instructs trainees how to transform themselves into different types of people. What endures is the story the trainee discovers of himself in which he not only recollects but *remembers* his own emotions. Memory brings the physician-author into the multidimensionality of deep time and re-opens possibilities for personal identity that professionalism attempted to negate.

Coda #2—Emplotment and Configuration

> *I still question the manner in which I delivered the news to the Smith family. Because of my doubt, I have read and investigated evidence-based literature regarding the delivery of bad news. As much as I dislike the actions of his friends, dropping his lifeless body off in our department, I am grateful to have had the experience to broaden my understanding of giving bad news, the key to which is simple: add the unique touch of human compassion and connection—a concept that is in blunt contrast to their cowardly actions.*

This coda is from "Reflections on Giving Bad News" (Gilmore, 2012, p. 358; italics added above) in which an emergency medicine resident recalls how he delivered bad news over the telephone to the parents of a 23-year-old man who arrived dead at the emergency room presumably from a drug overdose. The coda serves two functions, according to Labov's theory: It connects past and present events, and makes general observations about human nature. In terms of narrative, time, and identity, the coda illustrates emplotment and configuration, showing how the physician-author uses these to compose a narrative that, in contrast to medicine's master narratives of professional development, has enduring and existential significance for himself and other trainees as a human being.

The resident's narrative is a strategic retelling. Rather than recount exactly what happened as a chronological sequence of events in clinical time, the trainee temporally re-envisions his experience—"making-it-present" (Ricoeur, 1980, p. 172)--and recomposes it as a dramatic script for emergency medicine physicians who can with him enact "care" and "concern" (p. 168), qualities proposed by German phenomenologist Martin Heidegger that Ricoeur expands upon. As physicians read the trainee's article in *Academic Emergency Medicine's* "Resident Portfolio" section, the trainee-author rhetorically enjoins others, conscripts them, to take part in his experience of an unsettling

death by "tak[ing] it out of the external domain as an object of our concern"—which the culture of medicine does--and into "our concern in its existential constitution" (p. 168). In other words, the physician-author *carefully* connects singular events, bringing them together so they contribute to the development of the story of his life experience. This act of configuration leads to a narrative that is existentially meaningful for the author as well as other physicians: It "establish[es] humanity along with human actions and passions" (p. 174). The last word is especially significant, for in "Reflections on Giving Bad News," the narrative reinscribes into the practice of medicine what was critically missing for the physician-author: the perceptible human body that is capable not only of movement but intense emotion.

The trainee begins his narrative using imperatives and grammatical second person to prompt readers to re-enact his narrative with him (see excerpt below). He not only tells physicians what to think, say, and do in response to the character that represents him, "Dr. Gilmore"; he assigns them parts at the bottom of medicine's hierarchy in unfamiliar roles as parents of a patient who is old enough to render to them legally powerless: discordant roles in the context of their medical training.

> Imagine that you are a parent with a 23-year-old son…It is midnight and raining outside. The ringing phone jars you from your sleep. It rings a few times before you answer.
>
> "Hello?" You fumble and murmur, a little groggy still.
>
> "This is Dr. Gilmore from Thomas Jefferson University Hospital. Is this Mrs. Smith, mother of Jon Smith?"
>
> Confused, you affirm you are.
>
> "I took care of Jon tonight. I have to tell you about Jon. Are you sitting down?"
>
> "Why? Why would I need to sit down? Is he ok?"
>
> "Jon came to the emergency department tonight. I have some news, and it is not good."
>
> You are awake now.
>
> …

> You scream as you drop the phone and leave the room. Soon, your husband picks up the phone. "What happened?" he asks quietly. (p. 356)

What *could* have happened is the motivation for the trainee's article: "I wonder if I did the right thing by calling" (p. 357), writes the trainee. He moves beyond clinical time to narrative time, where he can reconsider how he could have told the parents to come to the hospital morgue to identify the body; how he could have requested the police deliver the news to the parents in person; how he could have stayed beyond his shift to tell the parents himself. He interrogates each of these scenarios, which would have been concordant with the cultural narrative he had been given to deliver bad news: "I received didactics, small-group, and simulation training in residency and medical school. I feel quite comfortable giving bad news in person" (p. 357). But the parents of the dead young man were not present. As he recalls how their bodies were absent from sight, the resident employs configuration, which enables him to identify the part of his story that endures: "It is difficult to emote over the telephone—the most meaningful aspects of communication are expressed through body language" (p. 357).

By re-scripting his experience, then, the physician-author finally can *emote*: "to conduct himself in an emotional or theatrical manner" (*Webster's New World Dictionary*). He reincorporates the body of Mrs. Smith into his narrative through the bodies of physician-readers who are told to "fumble and murmur"; to feel "groggy" and "confused." The author becomes aware of his own body as well when he uses perceptual skills to re-envision the mother and father. He remembers to takes into consideration their affective responses—"'Are you sitting down?'"—anticipating how their emotions are likely to affect their behavior and physical health.

Narrative then enables the trainee-author to remodel medical training outside the purview of the hidden curriculum. He references SPIKES, a mnemonic for a communication training tool developed to give physicians control over difficult conversations: "S" reminds physicians to "set the stage" by introducing themselves; "P," to perceive what the family knows; "I," to inform them in lay language; "K," to allow family members to react; "E," to empathize; and "S," to summarize (p. 357). With the coda, however, the trainee underscores the inadequacy of SPIKES in real-life encounters. He states precisely what the protocol lacks--"the unique touch of human compassion and connection"—and more importantly, points to the (dis)ability of physicians to touch and be touched through emotional perception. Even in a long-distance phone call, he suggests in his narrative, physicians can take into account the relevance of the body. Thus, the trainee-author emplots discordant and concordant events, grouping the events recollected through memory into a new temporality in which they contribute to and develop a meaningful narrative. The resident-author does not resolve the tension between what happened and could have happened, but configures the events by making-them-present, aligning them in profound time where, as a whole--a story--they reveal meaning that is existentially significant. The resident's narrative makes present an enduring concern for all physician-trainees: the essential humanistic and personal dimension of medical practice. The human body not only bares suffering; it bears meaningful communication.

Coda #3--Deep Time and Narrative Identity

> *The alarm clock on the nightstand informs me that it is now five minutes into a brand new day. Tomorrow we will be married. Together, we'll raise a family,*

> *change jobs, move, grow old, and go through life's struggles like a billion other families on the planet, like Rita and Bob. One day I will be dying, and she will come in and tell me it's OK to die. I'll listen to her. And it will be OK.*

"At the End of the Day" (Khorana, 2003, p. 243; italics added above), the coda rounds off the narrative by connecting the events of the past 7 hours to the present as well as to the physician-trainee's future. By doing so, the physician-author makes a critical observation about the relationship between love and death, which enables him to bring into concordance two intertwined narratives of emotional resistance, thereby recomposing the narrative of a physician's professional development to incorporate his personal self. The trainee can only come to this point, however, outside the hospital's medicalized time where he is enculturated to resist exploring, much less acknowledging his emotions.

One narrative centers on the professional responsibilities the resident tries to fulfill. An hour before his shift is scheduled to end, he admits Bob, "every physician's nightmare. A dying patient who hasn't had time to adjust, refuses to acknowledge the obvious, so won't sign the Do Not Resuscitate form" (p. 240). Yet, the resident also avoids discussing with Bob his impending death: "I evade the issue"; "I let it slide again" (p. 241). Only after his attending physician prods him—"'He needs to be DNR'" (p. 241)--does the trainee confront the patient, yielding to the demands of clinical time and the type of person it requires him to be. When the trainee notices the patient's "face covered with fear," the resident switches to "a different tone, a little harsher, with words like morphine, dying, and even futile," enacting a role that lacks empathy and compassion for another.

In the background of this narrative is another about emotional detachment in the resident's personal life. He is scheduled to be married the next day. "The nurse standing at the end of the counter reminds me of what I've been trying not to think about. 'Have you been practicing your "I do's?"' I smile back politely, not wanting to respond" (p. 239). After the trainee admits the dying patient, the nurse again references his upcoming nuptials: "'I'd think a peaceful last call before you leave for your wedding and honeymoon isn't asking too much, but I guess not,' she says. I shrug my shoulders and change the subject" (p. 242). To think about his marriage would require a different kind of subjectivity, vulnerable to the emotional vicissitudes of joining his life with another human being.

Both narratives are paradigmatic in the culture of medicine: They tell how the physician-in-training is transforming into a professional who successfully avoids acknowledging emotions that might affect his behavior by obeying the strictures of clinical time. However, when the patient's wife arrives, she complicates the situation. With three words that she says just once—"'It's…OK…Bobby'" (p. 243)--the wife persuades her husband to sign the DNR order, which the resident had failed repeatedly to accomplish. He describes the wife's voice as "strange"; her appearance "strangely incongruous"; and her actions make the hospital room "strangely silent" (p. 243). What seems so foreign to the resident, I contend, is the different understanding of time she introduces. Her presence is an embodiment of "making-present"; she interrupts clinical time by "coming forth," which encompasses "having been" as well. The immediacy and intimacy of her person is an "extension" (Ricoeur, 1980, p. 177) of the moment beyond the chronological measurability that characterizes medical time in which the resident is

being trained to live. Confused, the resident stares at the wife still in her waitress uniform with her name badge, "Rita: 11 years of serving you." Time takes on multiple dimensions, which enable the trainee to see the wife from a new perspective that is simultaneously past, present, and future. He notices "a gold band on her left hand, thin and weather-beaten, a testament to years of service of another kind. I, who have been wondering about marriage, wonder about theirs: How many years? Where are the children? What were your good times, your bad times, your regrets, your joys? In the end, and this is the end, is it worth it?" (p. 243). The resident begins to comprehend death in terms of the nuances of life; he glimpses how suffering and dying are inextricably woven with love. And just as love informs death, in much the same way emotions inform the practice of medicine; the trainee perceives that dying has a much more complicated meaning than *yes* or *no* on a DNR order suggests. Narrative opens to a "meditation on time to another horizon than that of death" (Ricoeur, 1980, p. 184); to memory which is "itself the spiral movement that…brings us back to the almost motionless constellation of potentialities" (p. 182). Thus, the coda reveals how through narrative time, the trainee's encounter with the dying patient and his wife offers a new perspective from which the resident can integrate two narratives of his self into a narrative identity in which he finds a meaningful and moral resolution. Namely, "At the End of the Day," the practice of medicine, like life and death, is suffused with human emotions. And the resident tells us in his final words, it is OK.

Conclusion

Findings from the narrative analysis are significant for they disclose how physicians' personal experience narratives flesh out my claims regarding the exigency of death and the genre knowledge narratives provide about physicians' professional conduct. Narratives articulate what the exigence of death means empirically to interns, residents, and fellows. Their accounts of real-life responses prove that death is the ultimate moral emergency for trainees. The dying patients whom physicians-in-training encounter are the embodiment of human suffering. They urge, if not demand that trainees confront their own need to know how to comport themselves; how to act and speak as medical professionals in accordance with their personal values and beliefs, information silenced by the hidden curriculum's master narratives of professional development. Thus, physicians' personal narratives reveal what institutional genre knowledge has withheld: how trainees' personal, psychological, existential, and professional insecurities surrounding death can disable the physicians even decades after an incident. Thus, physicians' narratives about their personal experiences function as oppositional narratives (Linde, 2001) in the culture of medicine. They are "countermemories and counterhistories, which are explicitly critical of existing power relations and of the official institutional memory" (p. 529). Physicians' personal narratives tell of the real trajectories of trainees' professional development, which do not follow the idealized model of the hidden curriculum: physician as rational, emotionally detached professional. Physician-authors renaturalize their trainee-selves as persons capable of fear and hope, grief and love in service to medicine. Their narratives offer multiple and shifting perspectives and possibilities of the self, revealing the malleability of a

physician's embodied identity: points I will elaborate upon in the next chapter where I argue that the disciplinary knowledge embodied in physicians' personal narratives is grounds for recognizing the narratives as a new genre of medical discourse.

Equally significant in this chapter is my finding that as oppositional narratives, physicians' discursive accounts of their personal experiences with dying patients reveal a new understanding of time that supersedes clinical time and the constraints it places on physician-trainees' identities. Reflection, a defining feature of narrative, allows physician-trainees to "turn around on the past and alter the present in its light, or to alter the past in the light of the present. Neither the past nor the present says fixed in the face of this reflexivity" (Bruner, 1990, p. 109). Not only does reflection afford trainees a multidimensional perspective of their self and possible identities; it enlarges their comprehension of time beyond the "more or less linear and uniform fashion" (Bruner, 1991, p. 1). A subjective, psychological understanding of time replaces the objective, chronological sense of time that characterizes medicine and other empirical sciences. With this understanding of time comes a different kind of meaning-making: "An understanding of temporality associated with the human realm of meaning is entirely different from that encountered in the natural sciences" (Crossley, 2008, p. 360). Narrative affords time to consider relationships and their role in meaning making; "we interpret the events around us in terms of connections and relationships…that constitute their meaning" (p. 360). Events come into focus not as objects outside of human existence as in natural science, but within the domain of the personal where they can be seen with "care" and "concern," and thus are meaningful to a person's existence. In this way, narrative extends time, expanding our understanding of how time not only relates to

our personal identity but makes the very composition of our human subjectivity possible. Through memory, we recall events, which we connect through emplotment and configuration, making meaning through the composition of stories that concern us as human beings. Narrative "is an irreducible dimension of *self-understanding*" (Ricoeur, 1991a, p. 30; italics in original); "life can be understood only through the stories that we tell about it" (p. 31): a truth espoused through the years by narrative scholars and theorists, perhaps most succinctly by Walter Fisher who called humans "*homo narrans*" (1984, p. 1) or "story-telling animals."

Narrative time is multidimensional: the deep unity of past, present, and future. Key to that unity is tension: the force of time spiraling back and forth evinced in physicians' personal narratives; the dialectic between concordance and discordance, as physician-authors recollect events and plot them into a life story. But concordance often is arrived at through the narratives we have been given, for we are "entangled" in stories, including "unspoken stories" (Ricoeur, 1991, p. 30). Among "the scattered fragments of lived stories" are the "*stories that have yet been told,* stories that demand to be told, stories that offer points of anchorage" (p. 30; italics in original). I suggest that physicians' personal narratives of their encounters with dying patients are precisely the "stories that demand to be told," the narratives "that have been repressed in the direction of actual stories which the subject could take charge of and consider to be constitutive of his *personal identity*" (p. 30; italics in original). As my analysis of the three representative codas evinces, the trainees' untold stories of their emotional, embodied experiences with dying patients are the narratives they need to tell in order to make meaning of their selves. Only in the telling of these institutionally unsanctioned personal

stories can physician-authors discern their own subjectivities, the part of themselves that remains: anchor points amidst the discordance of master narratives.

Physicians' personal narratives function, then, are essential to the personal development of the physician as a human being; to the composition of a physician's personal identity. Narrative analysis, which illuminates the relationship between narrative, time, and identity, substantiates the essential role of personal narratives in medical discourse. These narratives present the real-life, lived experiences of trainees; they recollect the institutionally repressed accounts of trainees that are necessary for physicians at all stages of their careers to read and experience, so they, too, may enter a new dimension of time, which affords them the opportunity to retrieve potential selves by making-present the having-been and coming-forth with a new personal identity as a whole person.

I also have shown that a narrative understanding of personal identity that is contingent upon a deeper understanding of time affords a new understanding of death. A patient's death does not mean the endpoint of medical care of and for the person, the termination of responsibility where death can no longer be postponed or negotiated with medical interventions. Rather, death demands physicians' attention to what matters most in life: to reconnect with the persons they were prior to medical school's enculturation process when their moral selves were not yet bifurcated from their physical bodies. By integrating narratives of their private selves with their professional selves, authors create "a complete physician" (Mueller, 2009, p. 135) who fully engage with patients as persons.

In the next chapter, I expand upon the narrative understanding of physicians' personal identity and reconsideration of death by moving from the microlevel of analysis of individual texts to the macrolevel of *discourse*. I identify and analyze dominant themes emerging from the study corpus; social actions that foreground the corporeality of physicians' experiences. When this phenomenological dimension of trainees' encounters with dying patients is added to the existential and psychological dimensions revealed through narrative, I contend that physicians' personal writing yields vital disciplinary knowledge, which warrants recognition of the writing as a new genre of medical discourse.

CHAPTER 7

RHETORICAL GENRE ANALYSIS: PERSPECTIVE WRITING AS *ANOTHER* GENRE OF MEDICAL DISCOURSE

Introduction

Three overarching themes emerged from my final stages of analysis of physicians' personal writing at the level of discourse, defined as "patterns and commonalities of knowledge and structure" (Wodak & Krzyzanowski, 2008, p. 6) identified across texts. These themes provide evidence that physicians' personal discourse functions rhetorically as the articulation of disciplinary knowledge about the culture of medicine that is crucially and critically important to the moral practice of medicine. Physician-authors repeatedly wrote about the challenges they waged against medicalized training and enculturation; counter-cultural practices of medicine at the end of life they developed; and the revolutionary, humanistic practices that enabled them to become physician-healers. Physician-authors recounted how they were unprepared by medicine's hidden curriculum for moral dilemmas that death presents, which prompted them to redefine appropriate professional behavior at the end of life. They revised medicalized end-of-life practices into ethical models of patient care by reconnecting with patients on personal levels, reconceptualizing death outside medicalized time; and reincorporating emotions into the practice of medicine. Thus, physicians' personal

discourse instructs physicians on how to remember the persons they were prior to medical school's enculturation process when their physical bodies and moral selves were not yet bifurcated by demands of professionalism. The discourse tells physicians how to integrate their personal and professional selves by disclosing perspectives on the practice of medicine that have been silenced in contemporary times. Therefore, I contend that the discourse comprised of physicians' personal texts substantiates the central argument of this dissertation: *physicians' personal writing about remarkable patient encounters that are published in medical journals should be recognized as another genre of medical discourse.* I propose that this genre be referred to as *perspective writing* and that the discourse comprised of physicians' personal texts focusing on death, the subgenre of *necrography*.

More specifically, findings from my rhetorical genre analysis prove that physicians' personal discourse is a discursive response to recurrent end-of-life conflicts and the exigence that death presents. Physician-authors recount their real-life encounters with dying patients from their postgraduate training "to stabilize experience and give it coherence and meaning" (Berkenkotter & Huckin, 1995, p. 4) when their experiences challenged what they have been taught. Trainees draw upon disciplinary teachings of formal and informal curricula, reproducing the culture of medicine while simultaneously resisting it. The discourse of *necrography* reveals taken-for-granted attitudes, values, behaviors, and norms in the medical culture even as it argues for counter-cultural practices that rehumanize patients and physicians. This genre knowledge, derived from the personal experiences of professionals-in-training, qualifies as "situated cognition" (p. 4) and constitutes social action (Miller, 1994). Furthermore, the genre knowledge

conveyed fulfills the primary functions of medical discourse defined by *The AMA Manual of Style* (Iverson et al., 2007), previously outlined in Chapter 4. *Necrography*, like the seven recognized types of medical writing, provides useful information, guides clinical decisions, benefits patients, is original, and makes novel observations.

Findings from my final analysis that draws upon material rhetoric attest to the originality and novel observations that characterize *necrography*. They also respond to my third research question:

> ***RQ#3:*** *How does the representation of the dying/dead body function in terms of material rhetoric as the* kairotic *body with particular significance for the doctor-patient relationship?*

Physician-authors tell how they observed the dying bodies of patients not as the end-point of medical care as taught by the hidden curriculum but as *kairos*. The bodies represent a critical time for physician-trainees who find themselves relating to the newly dead body, the *kairotic* body, in unexpected ways. As trainees' medical power diminishes, the power of the corpse increases, inverting the traditional doctor-patient relationship. The dead body "moves" into the position of authority. Powerless and vulnerable, physician-trainees are freed from restraints imposed about their self-identity by the culture of medicine. This novel observation of the *kairotic* body affords trainees the opportunity to move into a new rhetorical space beyond the scientific logic that has traditionally defined medicine. Here, trainees recompose their subjectivity as embodied persons aware of their own mortality who then realize their capacity to *care* for and heal patients. They reincorporate humanistic values of ancient Greek physician-healers to create a renewed practice of medicine that is personally meaningful and professionally sufficient. Thus,

the corpse functions as "inspiration," infusing physicians with a new sense of identity, which centers on the recognition of human mortality, their own as well as their patients'. What we see evolving in the discourse of *necrography*, I suggest, is a revolutionary understanding of the practice of medicine as *phronesis*. Restricted to neither science nor art, medicine is reinterpreted as the practice of wisdom, contingent upon narratives of their personal experiences as a means of knowing. Through recollection and "radical reflection" (Toombs, 1993) on their experiences *being* physicians, the authors of *necrography* escape the constraints of medicalized time. They bring forth the past into the present as they recollect their experiences as trainees and create new possibilities for the future in "deep time" (Ricoeur, 1991): the unity of past, present, and future. In *necrography*, and by extension the genre of *perspective writing*, narrative affords physicians the time and space to recompose their personal identity.

In this chapter, I elaborate upon these findings by analyzing the three dominant recurring themes of genre knowledge: challenges to contemporary medical practices at the end of life; countercultural practices created and enacted by physicians-in-training; and revolutionary practices, which have the potential to radically change how physicians care for dying patients by re-envisioning the relationship between bodies of the living and the dying. Figure 7 shows the schema for topics covered in the chapter: analysis of the themes that emerged from *necrography*; definitions of *perspective writing* and *necrography*; and the significance of *necrography*, in particular the conception of the corpse as the *kairotic* body.

Recurrent Themes of Genre Knowledge
- *Challenges to Medicalized Training and Enculturation*
  - *Medicine as a Culture of Blame*
  - *Fear of Subjectivity*
  - *Medicalization's Silences Surrounding Death*
- *Counter-cultural Practices of Medicine at the EOL*
  - *Humanity as Us* and *Them*
  - *Suffering and Death in Present Tense*
  - *Death Rituals as Re-naturalizing Death*
- *Revolutionary Practices of Renewed Physician-Healers*
  - *"Re-doctored" Role Models*
  - *Love in the Practice of Medicine*

Perspective Writing as Another *Genre*
- *Defining Terms*
- *Necrography and Other Genres of Medical Discourse*
- *Significance of Necrography: The* Kairotic *Body Opening to Humanistic Medicine*

Figure7. Schema for Discussion of Findings in Genre Knowledge.

Recurrent Themes of Genre Knowledge

Challenges to Medicalized Training and Enculturation

At the level of discourse, I identified in physicians' personal writing recurring questions about and refutations of the assumed truth of moral beliefs and values transmitted through the hidden curriculum. While these findings in themselves are not new, the discourse consolidates the information across decades and publications, which gives credence to the overarching significance of the themes. Physicians-in-training object to medicine's socialization process that negates personal responsibility through the enculturation of fear and blame; that denounces subjectivity in favor of institutional objectivity and depersonalizes trainees as it professionalizes them. Physician-authors call out inconsistences and contradictions in medical training, which confirm how the

institution fails to acknowledge that ethics in the practice of medicine is contingent upon personal identity as well as technological expertise (Hafferty & Franks, 1994, p. 867).

This disciplinary knowledge about the practice of medicine, substantiated through recurring challenges to medicalized training and enculturation, provides evidence that physicians' personal discourse qualifies as a rhetorical genre. Physicians acquire knowledge that is "situated cognition" and "dynamic" (Berkenkotter & Huckin, 1995), two key principles of sociocognitive genre theory. The information and understanding about the medical training and practice comes directly from the experiences of trainees who are both participating in and learning how to take part in the culture of medicine. The rhetorical form of this cognition—personal narrative—emerges from physicians' experiences as a means to "stabilize experience and give it coherence and meaning" (p. 4), exemplifying another key principle.

Following are analyses of three conflicting and contradictory situations physician-trainees confront: medicine as a culture of blame, fear of subjectivity, and medicalization's silences surrounding death. Each is illustrated with excerpts from the study corpus.

Medicine as a Culture of Blame

Physician-trainees are taught through observation and role modeling to absolve themselves of responsibility when medical mistakes are made, while at the same time to question the appropriateness of their actions. The result is an untenable struggle between self-censorship and self-awareness of their own moral disquietude, which brings on denial, blame, and shame in trainees as noted in the first excerpt below. These negative

affects pervade trainees' professional practice, creating a decidedly less-than-honorable ethos, according to physician-authors in the second and third excerpts.

- "Physicians were taught to bury their mistakes rather than examine them and look for the root system causes of failure." "…a pervasive culture of blame existed. No one would assume culpability. Why would they, when they could get away with blaming a subordinate?" ("Disclosure of Error," Gelderman, 2006, p. 632)
- "Academic medicine is a complex business. You have your hierarchy, and that has to be recognized…As for the attendings, they come out of their offices or their labs, and pretend to know internal medicine, when most of them do not. You end up covering for them, playing the CYA game, except that it's theirs you're covering and not your own" ("Innocent Bystander," LaCombe, 1995, p. 508)
- "There is no time for condolences or discussion…that would go against the grain of the general ethos of medicine. Machismo flows as freely around the table as the wine does. Women are not exempt…" ("The Machismo of Medicine," Dinniss, 1999, p. 929)
- "…I thought to myself, disappointed, *I don't understand! What did I do wrong*" (from "Refilling Empathy," Chang, 2012, p. 615; italics in original).
- "…I wonder if I have been using the wrong approach. 'Do you want to be put on the ventilator?' 'Should we perform CPR?' Maybe these are the wrong questions" ("Dogwoods," Wynne, 2012, p. 898).

To be *wrong* implies that one has inflicted harm upon another. For a trainee to believe that, in providing care to a dying patient, he has violated his oath as a physician to obey the most basic tenet of medicine—"Do no harm"—is egregious. It diminishes the resident's sense of his own humanity, replacing it with cynicism and pessimism, as the last two authors argue.

Fear of Subjectivity

Physician-trainees taught to censor their self-awareness likewise learn to distrust their bodies as vital instruments through which they come to knowledge. The institution of medicine values scientific knowledge and expertise learned through rational deductive reasoning and rote memorization; note the trainee's use of "contaminated" below. Objectivity, however, is an unattainable ideal in the practice of medicine (Hafferty & Franks, 1994). When trainees attempt to detach psychologically and ontologically from their selves, their subjectivity, they literally distance themselves from their patients, unleashing a cascade of negative psychological and professional side effects, alluded to in the second and third excerpts.

- "Doctors shy away from making educated guesses on the basis of what they see and hear…doctors and patients alike seem to view medicine as an absolute science, final and comprehensible." Yet, "the readings from our machines must always be filtered through our eyes and minds, where, inevitably, they are contaminated by the very subjectivity from which we have been trying to escape" ("The Demise of the Physical Exam," Jauhar, 2006, p. 550)

- "Memories of the chemotherapy and radiation I have received sometimes haunt me. When these fears occur, rationality and clinical acumen disappear, and I become a cancer patient trying desperately not to panic. My worries have been brushed away by my colleagues…" ("The Sharp Edge of Damocles," Self, 1999, p. 339)
    - "…I stayed rooted in that one-square-foot area beside his IV pole…." "In essence, he had ceased being my patient and had simply become a person approaching his final hours, and all I knew of this man was his odor…I was left with the unsettling feeling that I had not fully done my job as his physician" (from "The Physical Exam and the Sense of Smell," Bomback, 2006, p. 328)
    - "…on a ward round with a distinguished doctor. There was an unfortunate man, deeply jaundiced and cachectic—I don't remember what he was dying of. His yellow eyes watched us being taught at the bedside of each patient and when we came to his bed we all walked directly past…Not a word was said. Not a greeting. Not even a nod. A distinguished doctor but an incomplete man" (from "Personal View," Carmichael, 1981, p. 1388)

The final phrase in the excerpt above—"an incomplete man"—aptly characterizes trainees' criticism of medical training: They are taught to be a less than a whole person. They are instructed implicitly and explicitly to ignore awareness of their body, of uncomfortable feelings and thoughts, the sense of their own subjectivity. The culture of medicine tacitly teaches that to be a physician is to perform the dualism of mind and

body: to live as a mind distinct from a body, a partial person whose expertise nonetheless sets him or her apart from and implicitly above others.

Medicalization's Silences Surrounding Death

The institution of medicine continues to silence questions of moral behavior toward dying patients when discussion of the place, even the presence of death in medical practice is averted. Physician-trainees especially are placed in problematic situations when providing care for dying patients. They are postgraduate students with low status and little if any power in the hierarchy of medicine. Yet, they are assigned responsibility to care for numerous patients. Essentially, trainees are given authority with no power. Further complicating the situation is the fact that trainees are not fully enculturated, so many still carry with them perspectives on and questions about death that are not yet medicalized and conflict with what they are formally taught, as authors point out in the first two excerpts below.

- "I hesitantly began to question the care she was receiving from a dedicated and professional team. This culminated during one visit in my pleading passionately with a junior doctor that any active treatment be terminated." "…death is a reality and often a welcome friend" ("There Must Be a Better Way," Koffman, 1998, p. 1990)
- "Death is a release in Kabul, an escape from fear and suffering. The girl with 50% burns knows this. No marriage, no children for her, just a life of pain and misery. The little boy with no arms and no eyes knows this. He screams

and begs us as we redress his wounds" ("Their Simple Sorrows," Hettiaratchy, 1994, p. 1239)

- "As physicians-in-training, we learn how to save lives…yet our training deemphasizes the ways in which illness and suffering affects others—and the ways they affect us as we care for patients and experience loss. This omission is particularly unfortunate because our understanding of suffering is so fundamental to the quality of care that we give" (from "Mourning on Morning Rounds," Vallurupalli, 2013, p. 405)

The author of "Mourning on Morning Rounds" is a medical student who says she speaks for herself as well as the intern with whom she worked. Both were "grasping for some sort of emotional closure, for some sort of meaning in what we did not fully understand" (Vallurupalli, 2013, p. 405) after the unattended death of a patient. She concludes by suggesting that "when science fails to answer our questions, we need the correct tools in order to find meaning elsewhere—and to mourn" (p. 405). Within *necrography*, I suggest, are the discursive tools, the genre knowledge, which these trainees call for: personal accounts of attending to dying patients by physicians who reflect on their lived experiences as trainees from multiple perspectives and in doing so, find meaning.

Counter-cultural Practices of Medicine at the End of Life

Physicians' personal discourse undermines beliefs and values girding the hidden curriculum by recounting what physicians-in-training actually said and how they reacted to encounters with dying patients. The oppositional discourse breaks through silences

surrounding the end of life perpetuated by the culture of medicine. Simultaneously, it provides guidance, often as scenarios and/or scripts, to other medical trainees as well as practicing physicians on how to *be* a doctor in the presence of death. Thus, the discourse illustrates how form and content work together to convey genre knowledge of what is "appropriate to a particular purpose in a particular situation at a particular point in time" (Berkenkotter & Huckin, 1995, p. 4). In terms of *The AMA Style Manual*, the discourse functions as practical guidelines for making clinical decisions (Iverson et al., 2007, p. 4). Counter-cultural practices also exemplify how physician-trainees simultaneously constitute and reproduce the social structure of medicine or "duality of structure" (p. 4) when they revise the practice, illustrating another key principle of sociocognitive genre theory.

Three prevalent counter-cultural medical practices described by physician-trainees that are related to the care of nearly dead and newly dead patients are: recognizing the humanity shared by physician and patient, redefining death in the present tense, and renaturalizing death.[49]

Humanity as Us and Them

The discourse of physicians' personal writing explicitly dispels the tacit belief enforced through the hidden curriculum that physicians are categorically set apart from other human beings, that medical trainees are and should be "transformed into something

[49] Physician-writer Jack Coulehan uses the term "counter-cultural" in his call for "narrative-based professionalism" (2005, p. 897), which he believes "provides a counterculture of virtuous practice that may gradually displace the more negative elements of contemporary medical culture." While I agree that narrative is a powerful tool in medical education and training, I find his concept of narrative-based professionalism narrowly defined and thus of limited application.

other than lay persons" (Hafferty & Franks, 1994, p. 865). Not only do physician-trainees intentionally see their shared humanity in patients, as the resident-author of the first excerpt states; the values they put into practice break down cultural distinctions between Americans and people living and dying in different countries, underscored in the third excerpt. Accordingly, the discourse fulfills what medical editors consider the primary function of medical writing: information that will benefit patients (Iverson et al., 2007, p. 3).

- "My advice to any junior doctors out there who may be as naïve as I was is that we are all someone's relative…What we all can offer is some understanding and support, no matter what time and no matter who it is" (from "A Little Understanding," Matin, 2005, p. 97)
- "Death calls on our basic humanity." "Wise decision making and kindness are not mentioned in postgraduate medical curriculums yet are the very root of good clinical practice. Over-reliance on e-learning, competency frameworks, and tick box training my risk us losing that which is most valuable and most remembered in living and dying" ("The Kindness of Strangers," Palmer, 2008, p. 877)
- "But one thing you will never see in any of the EDs in the world I've ever been to is people not valuing human life" ("Where They Don't Value Life," Arnold, 2001, p. 357).

In Arnold's provocative article motivated by a colleague's remark about Asians not valuing life, the surgeon writes of his experience in a hospital in Seoul, Korea, where a resident cries as tells the American physician how he comforted the mother of a dead 5-

year-old boy. "I stood here peering into the heart of 'they,'" writes the physician. He names the Other, vividly describing what patients in Taiwan, Beijing, and other Asian countries look like; what they eat; what they say and do when family members die. More importantly though, he names what They share with Us: "Pain is the same. Anguish is the same. Suffering is the same. One of the greatest souvenirs we bring home from our travels is the newfound ability to see the universal in what on the surface seems otherwise familiar." The physician disarms dualistic thinking that divides not only the foreign from the familiar, but the physician from the patient: "We are united throughout the world with our contempt for the surgeon who sits at home, temporizing with one more test. We share in the despair of another young mother who has just lost her child, wherever she may be."

Suffering and Death in Present Tense

In the discourse of counter-cultural medical practices, physician-trainees are *present* to death: they open themselves to witness the suffering and dying of others. They notice death and take it in: what it means for individual patients and their survivors, as well as for themselves and for their own lives. They also consider what death presents to them and, in so doing, accept what death has to teach them, all of which counters the detachment and distancing emphasized in the medicalized model of education.

- "I believe there needs to be a shift in the paradigm of our medical education so that students as well as more senior physicians will be able to view death alongside birth as part of the normal life cycle…a patient's death should not

automatically be viewed as a medical failure with the attendant self-denigration of inadequacy but rather with the wisdom and comfort of acceptance of the inevitable" (from "The Intern Experience: Facing Death," Buxton, 2011, p. 785)

- "Never before or since have I been so directly involved with as many people dying." "…I had to believe some of the philosophy of the stoic Africans I cared for….It helped me to witness a belief system that allowed people to live with death and loss" ("Death and Medicine: A Personal Account," Peters 1990, p. 81)
- "That suffering is everywhere, and it's for everyone to acknowledge and share—hospital walls are no barrier to the radiating agonies of dying children and grieving parents…Yes, I'm reminded of it daily, but is it really any comfort to forget? Is forgetting even possible? Indeed, I've come to believe that it's psychologically and spiritually damaging for a person *not* to be forcibly reminded of all the suffering in the world." "…aren't we the lucky ones…we physicians, or we anybody whose profession puts us in the way of other people's pain?" ("The Question," Adrian, 2012, p. 2372)
- "I had hoped to learn about life in Angola…Instead, I've learned about death: how to recognize when it is imminent, how to tell families of its likelihood, how to maintain dignity; how to write the death certificate in Portuguese. I can't explain it, but I think in experiencing death, perhaps I am also learning about life." "Certainly part of what it means is to live with the constant

> presence of death ("Internship in Africa: Death and Life," Riviello, 2008, p. 354)

Living with death has taught these physician-trainees an additional vital lesson: "I am learning that maybe who I am, the reason I am on this earth, has something to do with being unafraid to lend my presence to death when I can do nothing to stop it" (Riviello 2008, p. 354). According to medicalization, death renders a physician irrelevant. Trainees cited here reject the fear that results from the denial of death. By recognizing death, they recognize new aspects of their selves through their experiences with others.

Death Rituals

The most radical of the subversive discourse in this section are rituals that physician-trainees create and enact in their practice of medicine. The discourse is inarguably, in terms of *The AMA Style Manual,* original data (Iverson et al., 2007). In calling for medical education to address physicians' need to mourn patients' death, one trainee notes how "from the earliest prehistoric funerary practices of hunter-gatherers, such as those depicted in the caves of La Chappelle-aux-Saints, we have sought to find meaning in death through memorialization and ritual. It runs counter to our nature to deny this impulse" (Vallurupalli, 2013, p. 405). Yet that is exactly what medical enculturation attempts to do: to deny the emotional and existential impact of death. Trainees counter by infusing meaning and significance into their experiences with death through ritual, described in the first excerpt below. Her actions renaturalize dying as an inevitable event in the life of all people. The trainee in the second excerpt represents a

counter-cultural role model who enacts his belief in a shared humanity, even with deceased patients. In the third excerpt, the resident acknowledges through photography the presence of death, as well as the suffering and pain that can pervade the end of life. In the final excerpt, the intern recognizes a spiritual dimension of life which as a physician, she continues to honor through a ritual originating during her nascent medical practice.

- "Finally, toward the end of my residency, I taught myself what my medical training had failed to reach me. I learned to stand at the head of a deathbed and claim small moments of reverence for death and the life it leaves behind" (from "Death Rituals," Lerman, 2003, p. 384)
- "How to open the window so a soul can leave" ("Thank You All for Coming," Taylor, 2004, p. 548)
- "During the next three years there were many more calls to the emergency room, more codes, and more pictures. With time, my pictures, each a vivid reminder of a shortened life, improved" (from "Portraits," Rowlett, 1990, p. 2798)
- "Half-remembered words from the end of a requiem mass came into my head, and I said aloud, 'May choirs of angels greet thee at thy coming'—less a statement of faith than a simple attempt to acknowledge the passing of a life. Since that day, I have never had a patient die and not say those words—my small attempt to remember what it is that we are ultimately doing: trying to protect our patients' lives" ("The Code," Treadway, 2007, p. 1274)

Treadway's ritualistic acknowledgement of a patient's life and death was created inadvertently when she "happened to be the last person" in a hospital room of an "unsuccessful" code. She later learned that other physicians had "rituals they perform when a patient dies—offering a prayer, a poem, a gesture—something that each has felt compelled to do" (p. 1274). She notes, "What is striking is that most of us do this in private. We don't share these rituals." This oppositional discourse, then, is the articulation of behaviors, values, and ideologies that have been silenced through the medicalization of clinical practice. It is also the positing of new values and behaviors. The counter-cultural practices of physicians-in-training represent "a repertoire of situationally appropriate responses to recurring situations" (Berkenkotter & Huckin, 1995, p. ix). "More appropriate," physician-authors might add, than even the disciplinary practices they learned as trainees, since the values and beliefs underlying the subversive practices are a better fit for physicians who desire to be whole persons and thus, are worth appropriating into one's own practice.

Revolutionary Practices and the Reinstatement of Humanistic Medicine

Whereas counter-cultural practices oppose the moral authority imposed by the institution of medicine upon physicians, revolutionary practices recounted in *necrography* represent drastic changes to the institutional practices of medicine. The practices of physician-trainees are as novel as original research that is regarded as "the backbone" (Iverson et al., 2007, p. 3) of medical writing. The discourse upends cultural role models, arguing that the most professional physicians are those who do not practice medicine per se. Their concern is healing, which, for dying patients, means physicians do

not terminate care when medical interventions are no longer effective; care begins anew. These "re-doctored" role models not only care for patients; they develop strong emotional bonds with patients whom they relate to as intimately as family members and unabashedly with love. Most revolutionary, however, is how these acts of medical insurrection invert the relationship between doctor and patient; how the dying/dead body takes on new power that actually invigorates the bodies and lives of physicians. Through the discourse of physicians' personal writing, trainees encountering death tell how they embodied ancient Greek conceptions of medical practice in which physician-healers focused on human relationships, the connection between the embodied person of the patient and that of the physician, which underlies medicine.

"Re-Doctored" Role Models

To be a physician attending to patients at the end of life, argue trainees in the excerpts below, means to *not* be a physician who is compelled to adhere to the medical imperative. It means to refrain from offering more medical interventions and treatments that may temporarily stave off death but will not and absolutely cannot, prevent it. The focus shifts from measuring the life of dying patients in weeks, days, and hours to taking measure of their lives: finding out what is important to each patient, described in the first excerpt, and helping that person to the extent possible to fulfill his desires before death, described in the third excerpt. Only then is healing possible, contends the physician-author in the last excerpt.

- "That evening, my attending and I went back to see Mr. D. one last time. I realized that I must still have something fundamental to learn about capacity

consults: as we entered Mr. D.'s room, I had no idea what my attending would say to him. To my surprise, she just talked with him about his life" (from "Who Has Capacity?" Brody, 2009, p. 233)

- "After five years of medical training, and two months with an unforgettable patient, I understand that, very often, the crucial decisions that I will make as a physician—the decisions 'that can easily enough be overlooked later on'—will involve simple acts, or errands, like listening to a patient talk about his dog or the last book he read, or running down to the cafeteria so that he can enjoy an apple one last time" ("Errands," Bomback, 2006, p. 733)
- "This is when you stop being her doctor" ("Princess Abra," Moorehead, 2008, p. 80).
- "In the end, I have come to understand that those are the times when I need to be less of a physician in order to be more of one" ("Giving Up," Cripe, 2009, p. 1748).

Cripe, in his eloquent and poignant response to a resident who accuses him of "giving up" on a 16-year-old patient who has acute myeloid leukemia, complications of diabetes, and a kidney transplant, admits, "I frequently do feel like I am giving up" (p. 1748). Yet, he neither abandons his responsibilities as a physician nor relinquishes his sense of his own person, his moral being. Instead, he re-envisions his role in a holistic and humane way: "Is there any more profound choice we physicians make than to encourage persons with life-threatening illnesses to attend to their life goals with the explicit realization that life is ending?" Furthermore, by phrasing his point as a question, the physician invites colleagues to enact their own "journeys of compassion": "to

remain fully aware of the experience—the suffering, the distress—of the person with a life-threatening illness who may be near the end of life whether or not I have an expectation of relieving the cause." By undermining the culture of medicine's tacit mandate to treat death as disease, Cripe models how to be a physician who offers patients the opportunity to heal and, in the process, wholly realizes his own potential as a moral being.

Love in the Practice of Medicine

Love signifies the most personal, most intimate of human affections and relations. It is "the ultimate and the highest goal" (Frankl, 1959/2006, p. 37) to which human beings aspire and that "finds its deepest meaning in [an individual's] spiritual being" (p. 38). Understandably then, it is the emotion from which professionals distance themselves the farthest. It is arguably foremost on the list of words silenced by the culture of medicine, even more so than *suffering* and *death.*[50] That *love* is used frequently by physician-authors in the study corpus is not surprising; they are revolting against the authority of professionalism and medicalization. Nonetheless, trainees seem surprised by the powerful presence of love at death. Just when life biologically absents a patient's body, residents and interns recount how love (re)connects bodies and lives in the most meaningful though inexplicable ways, which enable physicians to participate in

[50] In "The Word That Shall Not Be Spoken" (Lee, 2013), published in the *New England Journal of Medicine*, the physician-author remarks that for him and his colleagues, "the word 'suffering' makes us feel bad. It reminds us that we are powerless against so many of our patients' problems. Suffering demands empathy and response at a level beyond that required by 'anxiety,' 'confusion,' or even 'pain'" (p. 1778). He notes that the *AMA Manual of Style* instructs writers to avoid "'emotional terms that suggest helplessness (afflicted with, suffering from, stricken with, maimed'" (pp. 1777-1778). *Suffering* is "too complicated…too much talk about patients' suffering might distract clinicians from doing what they could to relieve it" (p. 1778), said one of his colleagues.

healing that has always been at the core, the heart, of medicine.

- "'Doctor, I know you loved my baby, and he knew it too. And that's as good as any medicine you could have given him'" ("The Legacy," Cozart, 1993, p. 1160).
- "…they told me something about the work that was difficult to articulate: that there was something about the work that sustained itself, that acknowledged death and injustice and love thwarted and hope extinguished and potential squandered without accepting them as facts preeminent over life and justice and love triumphant…" ("The Question," Adrian, 2012, p. 2373)
- "I could feel my heart opening to the children, a timid advance at first and tentative at best. But gradually they became for me more than mere cases: at first patients, they then became children, and family, my children, whom I grew to love unreservedly" ("Art and the Science of Medicine," LaCombe, 1995, p. 429)
- "'You love your brother very much, and so you feel his pain in your heart'" ("The Laying on of Hands," Weinberg, 1992, p. 84).
- "I gently close her mouth. Her face is so pale—so different from the pictures adorning the walls and her hospital bed. Angels hang everywhere. The cross prominently overseeing all. So much love…." ("The Long Goodbye," Guardiano, 2009, p. 499)
- "I know that what a mourner needs most is to be given love, acceptance and understanding" ('Death and Medicine: A Personal Account," Peters. 1990, p. 82).

The recognition and acceptance of the power of love to heal in the culture of medicine is revolutionary in that it reintegrates into the practice of medicine the belief and requirement that a physician establish a personal relationship with a patient. Although physician-trainees in the 21st century continue to pledge their allegiance to this classic value through recitation of the Hippocratic Oath, its importance is downplayed, if not negated, in the informal teachings of the hidden curriculum (Stern & Papadakis 2006).[51] Thus, for physician-authors to advocate for the incorporation of love in medical practice indeed represents a drastic change. They are not arguing for a return to ancient methods, rather, the reinstatement of values, including an "integrative, dialectical view of the body, self, and world" (Kleinman, 1988, p. 12), that medicalization has silenced.

In 5th-century ancient Greece, Hippocratic physicians or *iatros* were expected to "personalize" encounters with a patient; "to establish trust" (Bartz, 2000, p. 14). Physician-healers "would approach the sick from the position of a friend" (p. 15) so as "to establish a good and trusting relationship not only with the sick person but also with other members of the household" (p. 17). This "friendship between strangers" (p. 18) enabled the *iatros* to better understand the anxiety and suffering of the patient and family. Hippocratic physicians understood that "'[t]o help or at least to do no harm' must first be understood as part of a strategy of healing that is necessarily embedded in close personal encounters and interactions" (p. 16).

Admittedly, friendship is not synonymous with the love that physician-trainees experienced in the excerpted passages above. However, both affects share the quality of intimacy: a closeness and familiarity that physicians-in-training are taught to take

[51] See Appendix E for an ancient version and contemporary revision of the Hippocratic Oath.

seriously. During their 1st year of medical school--often in the 1st week--students at most American medical colleges participate in the White Coat Ceremony, a ritual in which they are cloaked with a doctor's white coat symbolizing the dual challenges they face: to excel at the art and the science of medicine. Students recite the Hippocratic Oath, publicly committing themselves to the ideals of the medical profession: "…I will remember that there is art to medicine as well as science, and that *warmth, sympathy*, and *understanding* may outweigh the surgeon's knife or the chemist's drug…" (Johns Hopkins University; emphasis added).[52] Students swear allegiance to an emotional intimacy with future patients and their families: "…I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, *whose illness may affect the person's family* and economic stability. *My responsibility includes these related problems, if I am to care adequately for the sick*" (emphasis added). When medical students graduate 4 years later, they repeat the Hippocratic Oath, again pledging in public to uphold classic beliefs and values, the ethos of medicine, but also to meet the "moral demands" (Polansky, 2000, p.47) of the profession: the "particular relation of the doctor to his or her own self" that "requires a combination of experience and reflection" (p. 48). However, as documented repeatedly in previous chapters of this dissertation, personal reflection warrants little if any attention in the hidden curriculum. Thus, when physician-authors reincorporate into their practice the fundamental necessity of establishing personal relationships with patients and their families, they are discursively waging an insurrection against the culture of medicine.

[52] Excerpted lines are from what is referred to as the "modern" Hippocratic Oath, a 1964 revision attributed to Louis Lasagna, academic dean at Tufts University School of Medicine.

In summary, disciplinary knowledge about practice of medicine conveyed through the three overarching themes identified—challenges to medicalized training and enculturation; counter-cultural practices at the end of life; and revolutionary, humanistic practices of medicine—qualifies as genre knowledge. Gleaned from trainees' lived experiences, the information is necessary for an individual to become an ethical member of the medical profession. Physicians' personal discourse fulfills the "powerful" definition of genre proposed by Charles Bazerman:

> Genres are forms of life, ways of being….They are environments for learning. They are locations within which meaning is constructed. Genres shape the thoughts we form and the communications by which we interact. Genres are the familiar places we go to create intelligible communicative actions with each other and the guideposts we use to explore the familiar. (quoted by Swales 2004, p. 61)

Necrography tells of physician-trainees' "ways of being" as they attend to dying patients. Their narratives serve as "frames for social action" that trainees and other physicians can use to learn how to construct new meaning from their own experiences. *Necrography* functions as "guideposts to explore the familiar." Death is a familiar and expected occurrence in the medical discourse community. Yet only through narrative do physicians "explore" the emotional, psychological, existential, and ethical terrain of the dying process that remains silenced and unfamiliar in the culture of medicine.

Perspective Writing as *Another* Genre

Physicians' personal writing should be recognized and given rhetorical stature as a formal genre of medical discourse. I propose that this genre be called *perspective writing*; physicians' personal texts that focus on dying and death, the subgenre *necrography*. In the remainder of the chapter, I explain the significance of these terms

and the significance that the recognition of *necrography* brings to the discipline and practice of medicine. *Necrography* illuminates taken-for-granted behaviors, attitudes, and values enforced by the hidden curriculum while simultaneously challenging and resisting these teachings. It disproves tenets of the hidden curriculum by revealing the extent of resistance and subversion by physicians and physicians-in-training. *Necrography* proves that the oppositional discursive responses to moral distress are not limited to the isolated experiences of individual trainees. They are expressed at the broader level of discourse across texts and time. Once accepted as a formal subgenre of medical discourse, *necrography* can be seen as a valuable resource of end-of-life literature that exists and is accessible *within* the discipline of medicine. Finally, *necrography* draws attention to new understandings of death represented by the re-conception of the corpse as the *kairotic* body, a radical reimaging of the body that has potential to influence medical education and practice.

Defining Terms

Perspective Writing

I selected the word *perspective* for the genre of physicians' personal writing because the four meanings combined encompass the significant characteristics of this type of discourse and aptly describe its rhetorical function: to provide a personal perspective on the professional practice of medicine. The first definition of *perspective* refers to "the art of picturing objects or a scene…" (*Webster's New World Dictionary*), which is applicable to observations of and reflections upon nonscientific scenes of doctoring described by physician-authors. The definition continues-- "…in such a way

as to show [the scenes] as they appear to the eye…"—which affords a particularly critical dimension to the word "eye." It connotes the doubled meaning found in physicians' personal writing: scenes are seen through the eyes, the physicality of their own bodies, as well as through the physicians' *I,* their subjectivity. The second definition of *perspective* specifies that the appearance of an object or scene is "determined by their relative distance and positions" and is "the effect of that relative distance or position." Physicians' personal writing that is published in medical journals is uniquely determined by the authors' professional position. In fact, as I have argued in this dissertation, this type of writing emerges from the conflicts physicians confront in their professional positions: the emotions and existential dilemmas they experience as private persons versus the detachment they are tacitly taught in the culture of medicine. The third definition of *perspective* means "the relationship or proportion of the parts to the whole…," which refers to the rhetorical nature of physicians' personal writing; that the articles have meaning at two levels, *text* and *discourse*. Physician-authors begin by describing their personal, individual experiences but rhetorically address broader questions relevant to others. Individual texts are "parts" of the "whole" discourse of the medical community. The definition further stipulates that the parts and the whole are "regarded from a particular standpoint or point in time," which succinctly describes the reflective quality of physicians' personal writing, especially the dominant rich feature of narrative in which a past experience is brought forth to the present so as to provide meaning for the future. Furthermore, narratives as defined in this dissertation are always recounted from the perspective of an embodied, thinking subject who is positioned in space and in time when s/he accounts for the events that have happened. Finally, the

definition of *perspective* means "proper evaluation with proportional importance given to the component parts," which likewise summarizes why physicians' personal writing published in medical journals should be recognized as a major type of medical writing. *Perspective writing* comments upon and evaluates aspects of medical training and practice that are indeed "proper": suited to journal audiences from whom the arguments are useful, if not necessary tools for the culture of medicine.

One additional argument for the appropriateness of adopting the term *perspective writing* relates to perspectivism, a philosophical position recently aligned with science. Perspectivism originated with Friedrich Nietzsche who identified himself as a "perspectivist" (Kidd, 2011), challenging positivism and its attendant "conceptions of scientific knowledge as objective and independent of the 'human contribution.'" Nietzsche argued against the traditional epistemological views of Plato, Descartes, and Kant, who each endorsed the existence of an objective reality knowable as Ideal Forms for Plato, objects for Descartes in his dichotomous view of the world as object versus subject, and the thing-in-itself for Kant. Nietzsche held that "everything that exists in the world is a distinctive perspective on everything else…humans impose attitudes, beliefs, and expectations upon the world and interpret or conceive the world accordingly" (Crosby, 2007, p. 58). Of particular significance to a discussion of perspectivism and medical writing is Nietzsche's emphasis on power and continual conflict "between a given center of power and the resistance or response it encounters from other centers of power" (p. 61); the "given center" being understood here as the culture of medicine and the "resistance or response" from "other centers," physician-authors. More recently, philosopher Ronald Giere has argued for scientific perspectivism as a synthesis of social

constructivism and "more realist views of scientific knowledge" (2009, p. 221). He asserts that scientific observation and theories are not objective, for "scientists are agents with interests and purposes" that necessarily influence how and what they see. By extension, the argument could be made that medicine as an applied science also is subject to perspectivism; that medical knowledge is perspectival and is influenced by human factors as much as by the world. Thus, medical like "[s]cientific truth-claims are relative to a perspective and are about the fittingness of perspectives" (Brown, 2009, p. 214).[53] Although I am not theoretically aligning *perspective writing* with scientific perspectivism, I maintain that the theories at least are not contradictory; if anything, scientific perspectivism could be argued to lend support to the choice of *perspective* in the genre name.

Necrography

The term I propose for physicians' personal writing that tells specifically of their encounters with nearly dead patients and newly dead bodies is *necrography*, which I position as a subgenre of *perspective writing*, though not subordinate in importance.[54] In

[53] One of the physician-authors in the study corpus (Miller, 2003) referenced "perspective" in a recent interview: "There's the perception that the world's knowable and concrete, and in fact it's not…" (Miller quoted by Sinnott, 2012). B.J. Miller, who practices at the University of California, San Francisco, Medical Center, studied perspective in undergraduate art history classes, which he drew upon when he underwent a double amputation after an accident." He said, "the study of perspective, how we perceive the world and ourselves…that was very relevant as I refashioned myself after my injuries. Whether we realize it or not, medicine…works with patients' sense of perspective around their illness, conceptualizing it."

[54] While I initially have limited necrography to physicians' personal texts, it arguably could be expanded to include writings about personal end-of-life experiences of other health-care professionals. It does not include personal narratives written by patients, their families, and significant others, which fall more accurately into the literary subgenre of "pathography" (Hawkins, 1991; also see Chapter 2 in this dissertation). Arthur Frank in his book *The Wounded Storyteller* includes an endnote in which he argues against the term "pathography" (1995, pp. 190-191). His primary objection, I suggest, lends additional support for the adoption of *necrography*. Frank writes, "I am unwilling to adopt…'pathographies,' because no ill person has ever called her story a 'pathography.' Medical language differentiates itself by attaching

the culture of medicine, "the underlying fact [is] that medical training always has been about death and dying and about acculturating students in the norms and values associated with working with the death and the dying" (Hafferty, 1996, p. 629). *Necrography* combines "-graphy," from the Greek word *graphein*, to write, and "necro-," from the Greek *nekro,* for dead person or dead body. Necro- has a three-part meaning in the unabridged *Webster's Third New International Dictionary*: it refers to "those that are dead; the dead; corpses" in both singular and plural terms. It also refers to "death" as an event, as well as "conversion to dead tissue," which suggests the dying body. Finally, it means "extinct" as in fossil which can refer to "any remains, impression, or trace of an animal" that is preserved and/or dug up from the earth. [55]

In the context of perspective writing, we can understand *necrography* more fully and more discretely. The "scenes" referenced in *perspective writing* refer in *necrography* to the clinical events and situations during which physician-trainees confront dying patients. "[H]ow they appear to the eye with reference to relative distance or depth" connotes how the (un)familiar corpse looks physically to the eye and meta-physically to the subjectivity of an individual physician and/or collective intersubjectivity of physicians. Additionally, this portion of the definition affords a phenomenological view of necrography, which I address in the next section.

Greek prefixes of 'patho.' To call stories 'pathographies' places them under the authority of the medical gaze." With *necrography*, I intend to place narratives directly within the medical gaze.

[55] Latin and other Greek terms were considered as names for this subgenre. The "combining form" of "necros" comes from the Greek *nekros* meaning "corpse," according to the *Illustrated Stedman's Medical* Dictionary (Basmajian et al., 1982). Forms of necros- appear in 27 entries in the dictionary, suggesting that necros is a familiar term in the medical discourse community. "Mors," the Latin word for death, and "thanato-," a combining form of the Greek word for death, are also both listed in the medical dictionary. However, mors appears in only five dictionary entries and thanatos-, in 11, which indicates that these terms are not used as often in medicine and thus are not as likely to have as much medical significance as necros-.

Necrography and Other Genres of Medical Discourse

The functions of *perspective writing* correspond to those of other types of medical journal writing, and, like those, *perspective writing* makes equally significant contributions to the discipline of medicine. Genre recognition entails more than typification or taxonomy (Miller, 1984) or the description of recurring features, as discussed in Chapter 2. Genres have a communicative function as social action (Miller 1984), helping people to recognize and know how to respond to recurrent situations. Genres "embody a community's ways of knowing, being, and acting" (Bawarshi & Reiff, 2010, p. 78). Within professional discourse communities, genres codify the knowledge produced (Berkenkotter & Huckin, 1995) and allow for dissemination. In medicine, disciplinary knowledge is communicated through seven distinct types of writing described in *The AMA Manual of Style* (Iverson et al., 2007). I review the major types and their respective functions to argue that a majority of these characteristics and functions can also be found in *perspective writing*. Physicians' personal writing is original, benefits patients, guides clinical decisions, makes novel observations, and provides useful information.

Original research articles are described by the style manual as "the backbone of medical and scientific communications" (Iverson et al., 2007, p. 3). Listed under the heading "1.1 Reports of Original Data" are "articles," "communications," and "reports," all of which present "new findings." I suggest that physicians' personal writing is by definition original; physician-authors write about their experiences precisely because they were and/or are in some way new. As discussed in Chapter 5, physicians write about what initially seem like routine encounters with dying patients, but which for some

reason stand out as unexpected, uncommon, and often uncomfortable experiences. In telling these remarkable experiences, a majority of physicians-authors in the study corpus report "new findings": new perspectives, new interpretations, and new meanings regarding their experiences.

Listed as "1.2" are "Review Articles," which the style manual states "have great practical importance because clinicians often use them as guides for clinical decisions" (p. 4). Physicians' personal writing functions in a like manner. In the previous section, "Re-Doctored Role Models," excerpts from the study corpus illustrate the practicality of *perspective writing*; how the descriptions of physician-authors' thoughts and actions can serve as guidelines for making decisions. The resident-author of "Who Has Capacity?" (Brody, 2009) watches the attending physician question a terminal patient who is refusing further medical treatment. It is neither the interview the resident was trained to perform nor what he anticipated; rather, the attending simply asks the patient about his life. The questions she poses that the trainee quotes—"Was there a particular accomplishment he was proud of?"; "Was there anyone else in his life he had discussed [his decision] with?" (p. 233)—serve as revised and, in this case, more effective lines of questioning to determine whether a patient at the end-of-life is impaired and unable to make decisions. In this way, the physician-trainee's article also is "a source of benefits for patients" (Iverson et al., 2007, p. 3), as well as "an educational tool" (p. 4).

Like "1.3 Descriptive Articles," *perspective writing* makes "novel observations that can stimulate research or should provide useful information about topics of particular interest to a journal's readership" (p. 4). What physician-authors say in prior excerpts about the role of love in the practice of medicine exemplifies "novel observations."

When one trainee recounts how the mother of a newly dead patient tells him that his "love" for her son was the best medicine; when another trainee tells how an older physician accurately diagnoses his relentless chest pain as evidence of the resident's love for his dying brother, they are using a "strange" word not commonly found on the pages of medical journals. It is decidedly unscientific language, although appropriate, precise, and accurate to describe what they experienced. And their experiences, especially those occurring at the end of patients' lives, do provide useful information to readers of medical journals, as has been argued in many of the previous chapters.

In summary, *perspective writing* should be recognized formally as *another*—a similar, but different--major type of medical writing situated within the hierarchy of medical literature. *Perspective* writing is not literary writing or pathography, which is situated within literary studies. The rich features of the discourse identified in Chapters 5 and 6 prove that *perspective writing* is rhetorical, not autobiographical as is pathography (Hawkins, 1999) and confessional writing (Wear & Jones, 2010). Neither does *perspective writing* share features with *praxis* literature—medical literature directed toward the practice of medicine as an applied science; "linguistically atheoretical" and quantitative with "talk as data" that focuses on "control over future action" (Ainsworth-Vaughn, 2001, p. 453). *Perspective* writing is not intended to give physicians control of communication. Indeed, many more examples of *perspective writing* analyzed in this dissertation describe physicians losing control of situations, losing their ability to emotionally detach themselves when patients die. For *perspective writing* is largely oppositional, even insurgent discourse that challenges the control that medicalization has negatively wrought on the culture of medicine. *Perspective writing* subverts the informal

curriculum that silences physicians as it medicalizes their persons, restricting their identities as embodied subjects capable of intense emotions when faced with patients' deaths and their own moral distress and existential suffering in response. Emerging from within the discourse of medical journals, *perspective writing* reverses the hidden curriculum, (re)claiming the values, norms, ideologies, and social practices that trainees and physicians call for to meaningfully and ethically practice medicine.

The *Kairotic* Body as Inspiration for Humanistic Medical Practice

The most compelling evidence that *necrography* qualifies as a genre of medical discourse and that proves the significance of its recognition is the novel observation physician-trainees make about the nearly dead and newly dead bodies of patients. *Necrography* tells how trainees re-envision death as a critical and opportune time, not the terminus of patient care where the physician is professionally absolved of responsibility but a terminus a quo: a renewed starting point of *care*. Physician-trainees revolt against the medicalized equation of death with failure, positing in its place a radical and nuanced understanding of death as *kairos*. This single Greek word has no English equivalent, but its multiple meanings are exemplified in the revolutionary discourse of physicians. They describe the power of the human body as it transforms at death—*kairos* as a critical time--into a corpse that they find themselves unexpectedly relating to—*kairos* as connection—as a source of understanding. The corpse provides physicians-in-training with insight into what it means to be human—*kairotic* body as inspiration: a finding that I suggest is as original as many other reports published in medical journals, especially when it is further analyzed through theories of material rhetoric, critical rhetoric, and

phenomenology.

Before discussing these four novel and original findings regarding the dying and dead body that physician-trainees conveyed through *necrography*, I review four major definitions of *kairos* and discuss their meaning in the context of medicine.

General Definitions of *Kairos*

Generally, *kairos* means "a more situational kind of time" (Crowley & Hawhee 2004, pg. 37) than *chronos*, or measurable time. *Kairos* refers to the quality of time as opportunity, as "an advantageous time" or an "'exact or critical time'" (Liddell & Scott quoted by Crowley & Hawhee, p. 37), a definition prominent in the discipline of writing and rhetoric studies. In theories of material rhetoric, *kairos* has a more complicated definition "resonating broadly—spatially, ethically, somatically" (Hawhee, 2004, p. 66). Somatically, *kairos* refers to "a critical, fatal spot on the body" (p. 66), which Homer described in *The Iliad* as "'where the collarbone parts the neck and the chest'" (Homer quoted by Hawhee, p. 66). Greek archers would target this "gap…in the otherwise protective skeleton" (p. 67); "such an opening is delimited and formed by collarbones…where the bones come together, but not completely." Implicit in this definition is also an ethical understanding of *kairos*--the archer aims for the right spot at the right time—as well as a spatial reference. Spatial connection figures prominently in the multiple meanings *kairos* has related to weaving: "the place where threads attach to the loom"; "the act of fastening these threads"; "web so fastened" and "a woman who weaves" (p. 67). Finally, *kairos* describes an aspect of ancient Greek practice of medicine. Physician-healers employed "bodily *kairos*" (p. 70): "the twin abilities to

notice and respond with both mind and body" (p. 71). They relied upon the perceptive skills of their senses, their own bodies, to evaluate the bodies of patients by observing, listening, touching, and smelling, all of which had to be performed at an advantageous time in order to arrive at an appropriate diagnosis.

Kairos as Critical Time

Death presents not only an opportune but a critical time to reflect on the meaning of a dead patient's life. Death invites the trainee to take the time to reconsider the patient and his family. In the excerpt below, the physician-author recounts an experience that initially seemed to end like many during her internship: Death is reduced to "an unsuccessful code"; medicalized shorthand that limits understanding of death to procedures rather than bodies and lives, which allows physicians to "bury our fear of death" through "silencing the parts of our brain that didn't really want to be this close to death" (Treadway, 2007, p. 1274). On this occasion, however, the end of the code marks the beginning of a relationship between an intern and a corpse.

- "For whatever reason, perhaps because I was alone, I was struck by the reality that a person had just died. I made myself turn around and look at the body of this stranger…I tried to imagine his family—who in minutes would be told that someone they loved had died and for whom this would be a devastating loss. And what of the person himself, who had died despite our attempt to pummel and pound him back to life?" (Treadway, 2007, p. 1274)

Kairos as Connection

The corpse as *kairotic* body is foregrounded in the next excerpt where it literally brings together the physician and mother of a dead patient, binding the bodies and bodies of two women through grief and horror. The on-call resident in "When to Touch" (Morse, 1990) is asked to pronounce the death of a 20-some-year-old AIDS patient whom she had met once. The trainee notes that she has pronounced patients before: It was a "strange" (p. 2225) though familiar procedure; a course of action she follows in which she dissociates from the person whose body she is required ironically to touch to confirm death. So when the patient's mother drapes her body over the body of her dead daughter, the resident is shocked viscerally and emotionally to the point that she clutches the mother.

- "That night, I went into the room and saw the mother stretched out across her daughter, holding her and weeping aloud. This was the first time I had seen someone hold or even touch the newly dead person. At first, I felt like an intruder…Her grief seemed endless—and private." "Clumsily, I tried to touch her, to comfort her, and then suddenly I was holding the crying mother close." "As she told the stories she kept touching her daughter: her hands, her face, her arms." (Morse, 1990, p. 2225)

As the text continues, we see how the corpse functions ethically as the *kairotic* body. Not only does the corpse weave together the two women physically and emotionally; the dead body proves to the physician-trainee that the intimate relationship she has established with the patient's mother is appropriate professionally and personally meaningful. The resident's final phrase is particularly significant: "even when it hurts" evinces how death

reconnects the trainee's mind with her body. She knows that to act professionally will cause her personal pain; she will hurt physically. But she cannot nor should she avoid the human suffering death presents.

- "I'm still experimenting with what's 'right' to do as a doctor, and I feel it was 'right' to involve myself this time. The mother needed someone to share her grief and horror about her child and the never-imagined disease from which she had just died. As a developing physician I'm learning that privacy can be respected too much, and that sometimes closeness is needed, even when it hurts." (Morse, 1990, p. 2225)

Kairos as Opening

In the third excerpt, the corpse as embodied *kairos* becomes a metaphorical as well as material opening through which the physician-trainee interrogates what it means to be human. Before the intern places his stethoscope on the chest of the dead patient, he recalls in "On Feeling Small and Crucial" (Miller, 2003) how:

- "I touched her warm forearm and looked at her body, my head also now cocked to one side. I suddenly realized how liberally my eyes were rolling over her, as if she were not there; my brain thought my eyes were acting rudely or maybe even naively, and ashamed they darted off. I certainly would not have looked at her this way if she were alive, I thought." (p. 778)

Like the resident in the previous text, the trainee disassociates his mind from his body in order to distance and detach himself from the dead patient. Yet, his description of his own eyes--"acting rudely"; "ashamed, they darted off"—is not that of the professional

physician who sets himself apart from others, particularly the dead body "othered" by medicalization. His are the eyes of a person who recognizes the corpse as the body of a fellow human being who, even in death, commands respect. The corpse as the *kairotic* body "moves onto a nonrational register" (Hawhee, 2004, p. 71), providing an opening beyond logic that permits a reverse interpretation of *kairos*: "the rhetor opens him or herself up to the immediate situation, allowing for more of an exchange" (p. 71). In this nonrational, nonmedicalized space, the intern describes how he as the professionally disabled physician responds to the corpse-as-rhetor.

- "Then I stood there dumbly…I looked around the room, first in the two chairs and then into the air above the bed, just in case souls existed and persisted. After all, I thought, she might want to or have to linger for some amount of time, and I certainly did not want to be caught denying her soul's existence…I felt very self-conscious over the next minute or so as I groped for an emotion that was recognizable. Finally, nearly arbitrarily, my brain decided that I should squeeze out a chuckle or a grunt, anything to return this fantasy to the external world. I chose to chuckle; that way, I thought, whatever was watching all of this, whether her soul or a nightcrawler under the side-table, could feel comfortable laughing too." (Miller, 2003, p. 778)

Here, the *kairotic* body is the more powerful agent in the doctor-patient relationship. The corpse as expired body inspires the intern's consciousness of his self; the dead body urges him to "grope for an emotion." The trainee's "nearly arbitrarily" response lacks intention; it is more akin to a reflex reaction of a body that lacks consciousness of subjectivity apart from its physical response. Indeed, the trainee sees himself

transformed by death into the object of "whatever was watching all of this": the corpse as *kairotic* body.

Kairotic Inspiration

In the final excerpt, the resident finds herself fully engaging with the dying body of an elderly woman. The trainee opens herself not only to the experience of bodily *kairos*—holding the patient's hand with her own, her fingers keenly sensitive to the fragility of the wasting body--but to the transformative power of "kairotic inspiration" (Hawhee, 2004, p. 71). As the dying body transpires into the corpse, it stimulates the young, very alive trainee to move into a new space outside the hospital's palliative care ward, a nonrational space where the bodies of each are familiar as human beings, no longer estranged in their delimiting roles as doctor and patient.

- "I put my stethoscope down on the bedside table. This was one of the first times that I had seen someone so close to death, and I marveled at the fragility of the life that lay before me." "I pulled a chair up next to the bed and gently took her tiny, frail hand in mine, moving it as little as possible for fear that I would break something or cause some sort of pain." "What would I do if she died at the moment, her hand in mine? Would I feel her go? Would her skin get cold right away? Should I record the time? Should I pick up my stethoscope and officially pronounce her death? What would her family say?" "I suddenly felt horrified. Not at the thought of spending time with this woman during her last moments, but rather at the thought of her having to spend *her* last moments with *me.* I did not know her….May she just wanted

to die in peace, without some scared, guilt-ridden stranger quivering at her every pause." (Ching, 2013, p. 67)

The trainee's initial reaction to the woman's active dying is horror, followed by guilt: emotions tacitly taught in the informal curriculum's culture of blame. What transpires during dying, however, is the inversion of rhetorical agency. As in the previous excerpt, the *kairotic* body takes over as the power shifts from the physician-trainee to the dying body whose gaze, eyes and subjectivity, commands the attention of the physician-in-training. They force even the trainee's body to recalibrate, changing her vital rhythms. In other words, the *kairotic* body invigorates the resident, inspiring a new level of self-consciousness in the resident that is life-affirming.

- "Then, as if to jolt me out of my paranoid delusions, her hand twitched in mine. I snapped back to her face and found her looking directly at me, though nothing else in her posture had changed. She gazed at me through warm, powder-blue eyes that I knew had captured a thousand memories….My heart rate slowed and steadied as I realize just how long *her* heart had been pumping before I had come along.

  "Years.

  "Decades.

  "There had been *billions* of beats before me; beats through elementary school and through the hard teenage years. Beats through Christmases and weddings, babies, and grandbabies, new friends and old jokes. What an *honour* it would be for me to be there, with her, at the moment that faithful muscle decided to stop. It was not something to be feared, but something that

> would inevitably come—and after years of pokes and prods and treatments from doctors, she knew it as well as I: that time was near. These moments were *her* parting gifts to *me*." (Ching, 2013, p. 67)

The resident's repeated references to time are particularly significant, for they underscore the quality of time as *kairos* that is beyond measure. It is the immanence, the continuance of years embodied in the dying patient, an understanding of which she passes on first-hand to the resident. In silence, the *kairotic* body opens to and infuses the resident with a different sense of time. We see this reflected as well in the title of her text, "43 Minutes": the time the trainee sat with the patient; the time it took to die. Although recorded numerically, the span of time disproves the medicalization of death that trainees are enculturated to uphold: Death is not a delimited event. When the resident imagined the patient dying, her first inclination was to perform medicine's time-defined procedures: "Should I record the time? Should I pick up my stethoscope and officially pronounce her death?" Instead, the resident experiences the "immanence, movement, and embodiment" (Hawhee, 2004, p. 67) that underlie all meanings of *kairos*. As she concludes, "To this day I still marvel at the vast expanse that lies outside the realm of physical medicine…" (Ching, 2013, p. 68); "it was a privilege that very few doctors take the time to truly experience. There was no chaos, no guilt, and no tragic sense of responsibility that clouded my thoughts or marred the purity of the situation."

For a medical professional, albeit one in training, to affirm the "purity" of death, to perceive death not as a negation of life but as a genuine experience *of* life that she is privileged to attend to is indeed revolutionary. She is not alone in her radical experience either. As the intern-author of "On Feeling Small and Crucial" remarks, "I had one of

these moments where the grace and the privilege of our profession are acutely obvious" (Miller, 2003, p. 778); "…just then I was contented to have been at all involved with the moment where life and death touch."

The corpse as *kairotic* body, then, repositions physician-trainees in the doctor-patient relationship rhetorically, somatically, and ethically. From this new perspective, trainees recompose their subjectivity as embodied persons who are necessarily related to those for whom they provide medical care by the fact of their shared human nature. Physicians-in-training recognize in their own person the mortality they attend to in dying patients, enabling them to practice medicine as moral persons. Reinvigorated with this new sense of embodiment, trainees avail themselves of a new understanding of time as movement as well as immanence. These last two meanings of *kairos* in particular illustrate how trainees in attendance to the *kairotic body* move into a fatal place in their own being, a space of personal vulnerability where they are infused with and transformed by kairotic inspiration. Hence, the intern who acknowledges how he feels both small *and* crucial (Miller, 2003) in the presence of the corpse, the resident who admits fear *and* acceptance of death (Ching, 2013). These physician-trainees handle dying and death in terms of both/and: as a solitary person left alone in a hospital room with a nearly/newly dead body, yet simultaneously together, in company with the bodies seemingly bereft of life that command their attention, demand they enter into relationship. In other words, the corpse as *kairotic* body animates in the physician-trainee the ability to transcend dualistic thinking that pervades medicine--life versus death; physician versus patient; mind versus body. The corpse instructs physicians-in-training how to practice medicine at the end-of-life as an embodied, moral person outside the professional and especially

temporal constraints imposed by the medical imperative.

Death teaches physician-trainees in the study corpus how to *be* physician-healers, *iatros* who exercise *phronesis* in their practice of medicine: "the clinical judgment that enables physicians to act wisely and for the good of their patients" (Montgomery, 2000, p. 61). Generally, *phronesis* is defined as "practical reason…the virtue of working out how best to act in particular circumstances that are not (and cannot be) expressed in generally applicable rules" (p. 60). Kathryn Montgomery says in her seminal book, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (1991), that medical knowledge "is phronesis—practical and applied knowledge—and not a matter of scientific principle alone" (p. 27). In more recent work, she elaborates: "Scientific knowledge is necessary; logic is essential; but they take their place in an activity that is narrative and interpretative" (2000, p. 62). Medicine should be "scrapping the science-art dichotomy" (p. 64) that "does not do justice to its character as a *practice*: the scientifically informed, experienced, well-reasoned care of sick people" (pp. 57-58). Instead, the focus in medicine should be on *phronesis*, which affords moral choice, "the essence of clinical practice, inextricably bound up with the care of the patient" (p. 64). *Necrography* is the substantiation of medicine as phronesis.

The Significance of Necrography: The *Kairotic* Body as Opening to Humanistic Practice

Death is a familiar and expected occurrence in the medical discourse community. Yet only through narrative and the personal reflection it entails do physicians explore the emotional, psychological, existential, and ethical terrain of the dying process that remains

silenced and unfamiliar in the culture of medicine. Regarded from the existential level of genres—where genres are understood as ways of being--*necrography* elucidates the fundamental nature of the practice of medicine as relational, material, and experiential; aspects of medical practice that are revitalized in medicine as *phronesis*. I expand on these aspects by discussing findings from a combined methodology of material rhetoric, critical rhetoric, and psychological phenomenology.

In terms of material rhetoric, the discourse of physicians' personal writing can be understood as "a bridge among human beings" (McGee, 1982, p. 27) and *necrography*, as "a social function which permits interactivity among people." Because these relationships are between people in lived experiences, they are necessarily material: "the whole of rhetoric is 'material' by measure of human *experiencing* of it" (p. 29; italics in original).[56] *Necrography* draws attention to the full spectrum of human experience through the inclusion of relationships with nearly and newly dead bodies. They are not marginalized as demanded by the medical imperative. Rather, *necrography* proves McGee's claim that "[e]ven the dead can participate" (p. 34). The corpse as *kairotic* body participates as it rhetorically "moves," as shown earlier in this chapter. As the body of a patient, the corpse takes part as a "follower," but as the *kairotic* body, the corpse takes over agency as "the leader," which draws the corporeal attention of physicians to the experiences of all of the bodies involved. *Necrography*, therefore, reveals the power dynamics of the doctor-patient relationship; it serves "to unmask or demystify the discourse of power" (McKerrow, 1989, p. 91), the core function of critical rhetoric. In

[56] In the concluding chapter of this dissertation, I expand on the potential of this line of inquiry. From the perspective of material rhetoric, Michael McGee proposes that rhetoric "is predominantly a study of practice" (p. 45) from which generalizations can be made and developed into a theory: a framework that could be used to develop a rhetoric of necrography.

particular, the narratives of counter-cultural and revolutionary practices argue for "possibilities of change" and serve as "intervention strategies…to effect social change" (p. 91). Thus, *necrography* highlights the relational and material aspects of medicine that define the practice of medicine as *phronesis.*

Necrography also argues for the primacy of experience based on bodily knowledge, which provides a vital means of reversing the power of medicalization upon the culture of medicine. Medicalization reinforces a dualistic practice of medicine "where there is a gap between lived experience and the scientific account of such experience" (Toombs, 1993, p. xv); between "the immediate pre-theoretical experiencing of the world of everyday life, and the 'naturalistic' attitude which involves an essential abstraction from the immediate experiencing in favor of a theoretical, scientific account." Physicians have intimate knowledge of the body as a biological organism; they "learn about '*the'* heart, '*the'* lungs, '*the*' metabolism" (p. 61), yet the body is "experientially absent"; a "*hidden presence*" (p. 61; italics in original). In their personal writing, however, physician-trainees reflect on their experiences attending to the bodies of the nearly and newly dead, which reveal the presence of their own bodies. Trainees testify how they are, in the words of the psychological phenomenologist S. Kay Toombs, "'embodied' in the sense not that I 'possess' a body but in the sense that I *am* my body" (p. 52); "it is by means of my body that I have access to the world in the first place." When the resident tells how she held the cachectic hand of the dying patient in "43 Minutes" (Ching, 2013), the trainee becomes conscious of her own hand, experiencing it as her living body at the same time it is the means through which she experiences the fragility of the patient's dying body. She experiences herself as "the lived body," as "an

embodied consciousness which engages and is engaged in the surrounding world" (p. 53). Thus, the resident is neither subject nor object; she is "being-in-the-world" (Merleau-Ponty, 1945/2012), which she can experience only through reflection upon her experience.

Necrography, I suggest, is such phenomenological reflection. It is the description of the lived experiences of physicians-in-training who, through reflection, discursively challenge the medicalized taken-for-granted values, beliefs, attitudes, and behaviors regarding death. In so doing, these physician-authors recompose death as lived experience, patients' as well as their own. Death is re-envisioned as a phenomenon *of* life: belonging to life, thus necessarily--emotionally and psychologically, existentially and ontologically--within the scope of the practice of medicine. Care of the patient does not conclude at death, for the experience of death exceeds the bounds of time as measured in hospitals, as medicalized. In phenomenological terms, *now* "is an integral part of a continuum—a continuum which incorporates not only the present now-point but those now-points which are just past, as well as future now-points which are to come" (Toombs, 1993, p. 3). Death is part of that continuum, which brings me to a final, though certainly not terminal, claim about the moral and practical necessity of recognizing perspective writing as a formal genre of medical discourse.

That is, *necrography* presents a novel perspective on medical care at the end of life that is perhaps best described of as "a profession in quest of a narrative," to riff on Paul Ricoeur's theory of narrative identity, discussed in Chapters 2 and 6. Physician-authors on an individual level compose texts that recount their personal experiences with the bodies of nearly and newly dead patients, personal narratives through which they

recompose a viable and moral personal identity that enables them to integrate their private person into their professional practice of medicine through a sense of time as recollection of past, present, and future: a remembering in which they make present who they have been and who they are coming forth. What we see in *necrography* on the social or institutional level is the discourse of a profession seeking an identity from the perspective of those still in training, novitiates who experience encounters with dying patients as an unexpected invitation, an opportunity to engage with another person with care and concern as human beings, beings-in-the-world inextricably related to one another. Through the personal discourse of physician-authors, the profession is able to recollect and remember, retrieving their "most basic potentialities inherited from [their] past" (Ricoeur, 1980, p. 176): namely, their capacity to practice as physician-healers, present-day *iatros* who embody the values of the Hippocratic Oath by exercising practical reason and wisdom they can learn only through experience. And central to this practice of *phronesis* is the experience of death that is learned from simply being with death, being with human suffering. As physicians-in-training testify, when they allow themselves *not* to be the doctor, they open themselves to the *kairotic* inspiration of the dying body, to the recognition of their own critical, fatal spot—their shared vulnerability as mortal beings-in-the-world--which enables them to confront death not as a failure of medicine but as the ultimate, essential lived experience to which they as physicians can and should respond with care, even love. This is the narrative identity that I read in the personal writing of physicians which is published in medical journals: a quest for a new professional narrative that is simultaneously and intimately personal. Necrography should be recognized, as should perspective writing, because this genre of medical discourse

uniquely articulates the "something that endures and remains across that which passes and flows away," to use Ricoeur's phrase, in the *practice* of medicine, the suffering that can never be mastered, because it develops only through our continual struggle as human beings reflecting on our experiences so we may understand what it means to be inextricably in relationship with others in deep time.

Conclusion

Perspective writing warrants recognition as a rhetorical genre and deserves status as another genre of medical discourse, because it conveys disciplinary knowledge that is critical to the profession of medicine. It provides information that guides clinical decisions, benefits patients, and makes novel observations that serve as *original* data: personal narratives that tell physicians-in-training how to intervene in the enculturation process that is medical education, so they can remember the persons they were and reincorporate their values and beliefs into the physicians they become.

Necrography, a subgenre of *perspective writing,* constitutes genre knowledge derived from physician-authors who reflect on how they would/could/should have attended to nearly and newly dead bodies encountered during their postgraduate training; situations that brought about moral distress for which their medical training formally and informally failed to adequately prepare them. Physicians recall the blame, guilt, and shame they experienced as trainees at the bottom of medicine's hierarchy, the fear instilled in them to avoid affective responses to the deaths of patients and to maintain a shroud of silence around the inevitability of death. In their discursive responses to the exigence of death, the conflicts between personal and professional values it presents,

physician-authors not only conceptually challenge the medicalization of training, they actively oppose the culture of medicine. Physicians' personal discourse rebels against institutional medical practices at the end of life and the cultural ideology that support them. It reveals the attitudes and behaviors inculcated upon physicians during their training, the "underlying, usually unexamined, value structure" (Hafferty, 1996, p. 629), which medicine as an institution conveys through "discourse practices, that maintain its social power, prestige, and privilege, and the doctor-patient relationship" (Barton, 2004, p. 99). *Necrography* is the discursive insurrection against the social power of medicalization, which impacts the doctor-patient relationship and the personal identity formation of physicians.

Though physicians-in-training and physician-authors have been spotlighted in this chapter, editors of medical journals also play significant roles, engaging in and supporting the recognition of perspective writing as another genre of medical discourse. Publication is the tacit recognition that physicians' personal discourse provides useful information that is clinically relevant to the practice of medicine and ultimately valuable to patients. As shown in Chapter 4, editors of the journals in the corpus were compelled at some point during the past 40 years to publish subjective accounts of physicians' encounters with dying patients alongside objective, scientific articles in medical journals. Thus, editors are complicit in challenging the fundamental assumption that medicine is foremost a scientific practice. They recognize that, since the latter half of the 20th century, the practice of medicine has been strongly influenced by society and culture. Journal editors accede to the significance of claims made by physician-authors who argue that medical training is morally detrimental. Evidence can be found in the titles editors

selected for journal sections that exclusively feature physicians' personal writing: "On Being a Doctor" in *Annals of Internal Medicine,* "Change of Shift" in *Annals of Emergency Medicine,* "Narrative Matters" in *Health Affairs,* and "Becoming a Physician" in the *New England Journal of Medicine*, among others. These titles suggest that journal editors recognize the moral enculturation that medicine imposes upon trainees, that "being a doctor" implies a different type of existence from what medical education teaches. Thus, the publication of *perspective writing* proves that the genre is beneficial, if not necessary for helping physicians learn how to make meaning out of professional experiences that seem routine but in fact are unfamiliar to the person they have become, experiences that impact their ability to affectively and effectively interact with others in their professional care.

Recognition of *perspective writing* and *necrography* as a rhetorical genre and subgenre of medical discourse is vital to the profession of medicine. The discourse provides personal perspectives on the professional practice of medicine. It underscores the material, relational, and experiential aspects of practice, its humanistic nature. At its heart, medicine is the relationship of human individuals, the experiences of real bodies relating to each other not as *other* but as beings who share in mortality, for "[w]ithout suffering and death human life cannot be complete" (Frankl, 1959/2006, p. 67). To be a complete physician who attends to the dying and cares for the person who is the patient means *being with* another whose suffering is different though fundamentally the same: the struggle to understand the meaning of the time we experience as human beings living in relationship with each other even through death.

CHAPTER 8

CONCLUSION

Summary

Death has undergone a metamorphosis in America. Advances in medical technology in the past 70 years have transformed death, considered for centuries a natural and inevitable event in human life, into a medical "problem" much like a disease that can be treated and resolved. The public, especially aging members of the large baby boomer generation born after World War II, expects that physicians not only can but should stave off death through a seemingly endless array of medical interventions. Physicians as representatives of the institution of medicine are complicit in this medicalization of death. They temporize or postpone death by adhering to the "medical imperative" that has become a precept of contemporary medical education and practice: prevent death through technological intervention at all costs.

For physicians-in-training—interns and residents who have earned their M.D. degrees but have not yet completed clinical training, as well as fellows—encounters with dying patients can be problematic. They have acquired neither the experience nor professional acumen to know how to manage the emotional and existential anxiety that death can present. Trainees have been taught in formal didactic sessions that humanism—compassion, empathy, respect, and integrity, among the key qualities—is

essential when providing patient care. Informally, however, they learn through medicine's "hidden" curriculum to disregard these values. In conversations outside patient rooms, in comments overheard in hallways, through role modeling by attending physicians during hospital rounds, trainees learn to adopt negative attitudes and behaviors in order to become members of the profession. They are tacitly taught to affectively detach from patients, to distance themselves from dying patients whose pending death points to their technical inability and professional inadequacy. As a result, many physician-trainees experience moral distress. Not yet fully enculturated into medicine, trainees suffer troubling emotional, psychological, and existential responses to death when their personal values conflict with the demands of their professional identity.

To remediate the documented moral distress of physicians-in-training, courses in medical ethics, medical humanities, and professionalism, all of which draw upon content from other disciplines, have been added to the formal curriculum. While their effectiveness continues to be debated, scholars, educators, and physicians alike agree that personal reflection needs to be incorporated into postgraduate medical education; reflection on personal experiences is critical to helping trainees as well as practicing physicians deal with the disquieting personal aspects of professional medical practice. Through my experience teaching writing to medical students and leading literature discussions with physicians, I have found and used numerous examples of physicians' reflective, personal writing published in medical journals. Although solicited by the journals and subjected to peer review, these texts are labeled "other types" of writing. I wondered why this existing body of discourse was not given rhetorical recognition and categorization within medical literature, which would underscore its potential usefulness

to physician-trainees particularly in terms of end-of-life patient care. Accordingly, my purpose in this study was to rhetorically analyze physicians' personal writing published in medical journals, accounts in which they reflect on their experiences as trainees encountering dying patients. I specifically wanted to determine whether these personal texts shared discoursal features that would qualify the writing as another, as opposed to an other, genre of medical discourse. Second, I wanted to discern any recurrent themes that would reveal physicians' real-life attitudes and behaviors toward the care of patients at the end of life. Third, I wanted to examine how physicians articulate their relationship to the dying body as it transforms at death to a corpse, which might yield new perspectives on the doctor-patient relationship that is the core of medical practice.

To answer my first research question, I used the methods of discourse analysis, narrative discourse analysis, and rhetorical genre theory to analyze a corpus of physicians' personal texts. I collected 126 articles written by physicians about their experiences with dying patients encountered during their postgraduate clinical training. The articles were published in 14 medical journals that focus on primary care. The texts date from 1968 in Great Britain and 1978 in the United States, years when the journals inaugurated sections for personal or reflective writing. Physicians' personal texts are broadly identifiable by: the absence of standard scientific formatting (introduction, methods, results, discussion); use of grammatical first-person, as opposed to third-person; and the predominant use of active voice. Using inductive discourse analysis, I identified an additional six "rich" discoursal or linguistic features that further distinguish the texts from other types of writing in medical journals. Rich features are particularly appropriate to genre analysis, since "[m]eaning arises in large part out of the patterned use of these

features…repeated within and across texts" (Barton, 2002, p. 24). Further, texts and contexts have a reciprocal relationship that rich features illuminate. Inductive discourse analysis allowed me to examine the medical journals' stated goals for the sections in which the texts appeared as well as authors' submission guidelines, both of which defined the context.

To analyze narrative, the predominant rich feature of physicians' personal writing, I used narrative discourse analysis, also referred to as narrative analysis. Whereas discourse analysis enabled me to discern the intentions of medical journal editors in publishing physicians' personal writing, narrative analysis allowed me to investigate the intentions of physician-authors. I adapted a method developed for analyzing personal experiences narratives (Johnstone, 2001, 2008; Labov, 1972, 2007**;** Labov & Waletsky, 1968; Shiro, 2003), which outlines five stages of narrative. I focused on three levels relevant to my research questions: complicating actions and their preconstruction, evaluative expressions, and codas. I identified six procedures or events that constitute complicating actions: sequences of events that lead to the narrative's highest suspense. I also traced a recursive chain of events from the complicating action, which constituted the narratives' preconstruction and revealed the reasons why the events were told by the author. I analyzed evaluative expressions in each of the corpus texts, which authors use to tell audiences why they should read the narratives. I also analyzed codas, short summaries concluding the texts that often connect the significance of past events to the present.

To answer my second research question, I used rhetorical genre theory to verify that the discourse comprised of physicians' personal texts constitutes another genre of

medical literature. I drew upon sociocognitive genre theory (Berkenkotter & Huckin, 1995), since it focuses on academic disciplinary communication and emphasizes how essential genres are to professional success. I used the theory's five principles as an evaluative framework to analyze physicians' writing at two levels, individual and professional, which allowed me to determine how the significance of the texts extends beyond the expression of personal experiences to the generation of disciplinary knowledge. The methodological framework also enabled me to identify genre knowledge in the culture of medicine and conflicting ideologies surrounding dying and death.

Finally, to answer my third research question regarding the relationship between physicians-in-training and the nearly/newly dead body, I used rhetorical analysis and drew upon theories of phenomenology and material rhetoric. Phenomenology (Toombs, 1993) allowed me to focus on physicians' texts and discourse as descriptions of lived experiences and radical reflections. Material rhetoric (Hawhee, 2004; McGee, 1982) provided a theoretical model of the human body relevant to medicine and a method with which to examine the rhetorical relationship between physician-trainees and the bodies they are professionally assigned to care for. Since the theories of material rhetoric I used are inherently critical, they added to my investigation a focus on power, which is embedded in the culture of medicine at multiple levels, though often is only tacitly acknowledged or silenced.

In the remainder of this summary, I synthesize and analyze data discussed in Chapters 4 through 7 in which I reframe patient care as a rhetorical situation and identify death as an exigence for physicians. The discourse of their personal texts published in medical journals constitutes a discursive response. Salient patterns of recurrent linguistic

features identified across the texts qualify the discourse as a similar, though different genre of medical discourse that I propose as *perspective writing*. Using examples from a subgenre that I call *necrography*, I verified the genre through a sociocognitive framework of rhetorical genre theory. Across *necrography*, I found recurrent themes that disclose taken-for-granted knowledge regarding end-of-life patient care, as well as ways in which physician-trainees challenge, resist, and subvert these tacit tenets of professionalism.

By examining physicians' personal writing through a rhetorical lens, I resituated the discourse outside literary studies, where scholars and medical editors have relegated it. I reframed physicians' personal texts as discursive responses to a rhetorical situation in medicine: an as-yet-unrecognized confluence of social, political, and medical events that occurred in the United States and Great Britain during the mid- to late 20th century, which resulted in the increased biomedical and social authority of medicine, including new power over death. Dying was transformed from a naturally occurring life event into a medical problem that physicians were trained, and expected, to manage, if not solve usually through technological interventions. Physicians' personal writing about their experiences with dying patients, which medical journals recognized and accommodated by adding new sections for their publications, constituted discursive responses to the new exigence that death presented in the practice of medicine.

Moreover, physician-authors challenge the medicalization of death that dehumanizes physicians as well as patients, evident in the authors' resistance to using impersonal conventions of medical discourse. In their place, physician-authors employ five rhetorical tools that function as "rich" discoursal features distinguishing physicians' personal discourse from other types of medical writing published in journals and that

provide evidence for recognition of the discourse as another genre. Physician-authors claim authority by strategically using the linguistic tools of repetition, metadiscourse, emotive language, metaphors and euphemisms, and narrative to describe their professional experiences from personal and partial perspectives. Narrative, the predominant rich feature, affords authors the strongest rhetorical tool to assert their individuality. Physician-authors use personal narratives to recount the moral distress and physical discomfort they experienced as trainees when behavioral norms in the culture of medicine conflicted with their own ethical principles. Thus, the accounts of their personal experiences function as oppositional narratives in the culture of medicine. Rather than temporize the death of patients—treating it as a medical problem that can be indefinitely postponed—so they can move on to the next medical problem, physician-authors return to their encounters with dying patients and reflect upon their experiences in order to understand and give meaning to their emotional, psychological, and existential responses.

Recurrent themes regarding end-of-life patient care that emerged from the rhetorical genre analysis of physicians' personal discourse substantiate the significance of physicians' personal writing to the discipline of medicine and warrant its recognition as *necrography,* a subgenre of *perspective* writing. Physician-authors resist medicine's prevailing culture of blame, object to fears attached to subjectivity and affective expression, and contest medicine's amoral enculturation. In place of these attitudes and behaviors tacitly endorsed by the hidden curriculum, physician-trainees tell how they revise the medicalized role of the physician into a realizable, ethical model. They reconnect with patients on personal levels, reincorporate emotions into the practice of

medicine, and reconceptualize death outside medicalized time. Although unsanctioned by the culture of medicine, this knowledge derives from trainees' real-life experiences and qualifies as situated cognition (Berkenkotter & Huckin, 1995). It gives physicians critical, vital disciplinary information. It reveals attitudes, values, and behaviors, taken-for-granted perspectives on the practice of medicine that have been silenced in the culture of medicine. More importantly, it instructs physicians how to integrate their personal and professional selves when attending to dying patients.

Necrography, and by extension *perspective writing*, provides access to the personal reflections of physicians who have experienced problematic situations in their practice of medicine. Scholars, educators, and physicians have increasingly called for reflection to remediate and correct the negative effects of medicine's hidden curriculum. In terms of dying and death, *necrography* recounts and accounts for the experiences of physicians-in-training who reflect upon troubling encounters with patients who were nearly dying and newly dead. Particularly significant is trainees' relationship with the bodies of these patients. *Necrography* articulates a new relationship that inverts the traditional model empowering physicians over patients, which provides a foundation for shared decision making. At the end of life, physicians' medical power diminishes and the power of the dying/dead body, the corpse, increases. This new perspective frees physicians from the restraints imposed upon their personal identity by the institution of medicine, thereby enabling physicians to recompose their subjectivity as embodied persons and to practice as physician-healers. Thus, *necrography* tells how physician-trainees are "inspired" by the corpse, which opens a new understanding of the practice of medicine that is in fact an ancient one. Medicine is reinterpreted as *phronesis;* the

practice of wisdom which draws upon the humanities as well as science and is contingent upon narrative as a means of knowing.

Interpretation

This dissertation has drawn from interdisciplinary scholarship to formulate and answer research questions; accordingly, the findings are significant for particular disciplines as well as across disciplines. Recognition of *perspective writing* as a genre of medical discourse contributes to writing and rhetoric studies by expanding rhetorical genre theory in a medical context. It also extends theories of medical discourse. Understanding the rhetorical function of physicians' narratives—how and why physicians publish personal accounts of their professional experiences—expands narrative inquiry in health communication and extends narrative theory in medicine. Identification of *necrography* as an existing corpus of personal reflection that responds directly to the hidden curriculum represents a significant contribution to medical education, especially professionalism. In addition, the reconceptualization of the corpse as the *kairotic* body presents a new theoretical model of the body relevant to material rhetoric, body studies, medical humanities, and medical education and practice.

Perspective Writing

The recognition of *perspective writing* as a new rhetorical genre extends genre theory. Although physicians' personal texts have been published in American medical journals since 1978 and in British medical journals since 1968, I found no scholarship in which the texts have been collected and rhetorically analyzed at the level of discourse.

Previous research has focused on the discourse of patients' hospital forms and of allied health professions including occupational therapy, midwifery, and genetic counselling. In medicine, rhetorical scholars have analyzed case presentations in medical education, psychiatric diagnostic categories and end-of-life conversations between doctors and patients. Thus, the identification of *perspective writing* as a new genre represents a significant contribution to rhetorical genre theory. It opens up for further research an extensive body of texts in medical journals that have yet to be analyzed.

Recognition of *perspective writing* also extends rhetorical theories of medical discourse (Ainsworth-Vaughn, 2001). The genre qualifies as *praxis* literature, relevant to physicians' professional practice, but also provides for discursive examination of the medical encounter from a new perspective—the physician's—that has human implications for patients and physicians alike. Current theory distinguishes *praxis* literature as singularly relevant to the practice of medicine. Medical encounters are generally understood in terms of conversations between physicians and patients during medical encounters; narrative is limited to storytelling by patients. Thus, *perspective writing* expands theories of medical discourse and helps to dispel medicine's traditional binary thinking that regards literature as either related to medicine as a science, thus valuable, or outside the discipline and marginally relevant. *Perspective writing* illustrates the value of discourse that is both/and.

Narratives of Personal Experience

The identification of personal narrative as the dominant discoursal feature of *perspective writing* contributes to narrative theory across disciplines, especially in health

communication and medicine. *Perspective writing* expands narrative inquiry, as the theory is referred to in health communication, drawing attention to the unrecognized and pernicious power dynamics that medicalization has imposed on individual physicians, particularly physician-trainees. These individuals who are only partially enculturated into the profession represent a new population to study whose use of personal narratives is similar in some ways to patients, but also functions in unique ways. Narrative inquiry has focused on patients' illness narratives and more recently, health narratives. Illness and health are considered social constructions; narrative empowers patients and families to reconstruct the understanding of each concept and thereby enable lay persons to find meaning in their medical experiences. The addition of physicians' personal narratives that oppose, resist, and subvert the institution of medicine has the potential to increase narrative understanding of medical experiences by encompassing these new perspectives.

In the discipline of medicine, *perspective writing* represents a significant contribution to the understanding of narrative's function. Physicians' personal narratives, the key feature of *perspective writing*, present new ways in which physicians use narrative professionally as an educational tool and, more importantly, how they use narrative personally to (re)construct their personal identity as medical professionals. Physicians can look to the personal texts of colleagues that are published in medical journals as professional education. The discourse uniquely instructs them on how others have confronted dilemmas in which their personal values conflict with professional expectations, how others have encountered and responded to ethical challenges that are silenced in and by the culture to which they belong. *Perspective writing* tells physicians what it means professionally and personally to *become* and how to *be* a physician. The

genre proves how narrative has enabled other physicians to make sense of their personal experiences in medicine: to step outside medicalized time that they have been enculturated to accept as normal and to reflect, thinking back on problematics times, especially those that involved their patients' and/or their own suffering. Narrative allows for the emotional, psychological, and existential exploration of troubling experiences that medicine engenders but does not permit time for processing. Narrative offers physicians the means to formulate a personal identity that encompasses both professionalism and personal integrity, that helps them develop into complete physicians. This function of narrative has not been fully recognized or developed in current theories of narrative and medicine. Most focus on patient narratives, which physicians are encouraged to listen for using literary skills. They learn how to interpret narratives; to discern attitudes, values, and beliefs that are and are not expressed; and to integrate these into their treatment plans. Narrative is seen as a valuable clinical tool to improve their relationship with and care of patients. It is also recognized as a way that medical knowledge is structured. *Perspective writing* adds a new function of narrative, offering benefits that exceed those of existing theories. It exemplifies the usefulness, if not critical value of narrative in education, clinical practice, professionalism, and personal identity formation and development.

Necrography

Necrography, a subgenre of *perspective writing*, contributes to medical education, particularly professionalism, as a viable remediation to the hidden curriculum. It proves that personal reflection is a meaningful response to the medicalization of dying and death.

Further, it substantiates the significance of discursive personal experience narratives by drawing attention to their solicitation and publication in academic medical journals whose editors implicitly value the disciplinary knowledge the discourse communicates. *Necrography* is comprised of physicians' narratives of their encounters with nearly dead patients and newly dead bodies from which they have been enculturated to distance themselves, to disregard any personal affective or physical responses to encounters with dying and death. Physicians-in-training often find these tacit teachings untenable in their real-life encounters where they find themselves relating to dying and dead bodies as fellow human beings whose death mirrors their own mortality. Anxiety morphs into moral distress, prompting trainees to discursively reflect upon their experiences. By re-ordering events outside of medicalized time, they find new meaning in their experiences. They challenge, oppose, and resist the hidden curriculum. Their narratives do not resolve their moral dilemmas; they do reveal, however, the fallacy of medicalized death. The end of life is neither a medical problem nor can it ever be resolved. Instead, *necrography* tells how physician-trainees have discovered meaning and often a renewed sense of what it means to be a physician and a healer. *Necrography* tells how physicians through counter-cultural and revolutionary practices have been able to live up to the values they ritualistically promise to uphold in the Hippocratic Oath. Further, these are regarded by the profession of medicine as credible accounts. *Necrography* is published in official medical journals, established and funded by professional medical societies and edited by physicians. In fact, the journals added pages to accommodate physicians' personal texts which attest to their value. Thus, *necrography* represents a significant contribution to medical education; it consolidates and codifies practical knowledge into a recognizable

corpus. It illuminates a corrective to the hidden curriculum that already exists within the discipline of medicine, a valuable though overlooked resource of original medical literature.

The *Kairotic* Body

Lastly, the reconceptualization of the corpse as the *kairotic* body, an understanding that emerges from *necrography*, is a contribution from this dissertation with perhaps the widest theoretical significance. The power of the dying body as it transforms into a corpse is privately acknowledged by physicians yet has not been theoretically explained. By drawing upon material rhetoric, critical rhetoric, and psychological phenomenology, this study provides a new conceptual understanding of the newly dead body that should prove useful in medical education and practice. Previous scholarship in rhetoric has focused mostly on the cadaver: a body that has been dead for some time, which is used primarily for anatomical and pathological education of 1st-year medicine students, and less frequently for training physicians in new surgical techniques. The theory of the *kairotic* body is applicable to medical practice as well as medical education; it explains how the newly dead body "inspires" physicians to confront their own mortality, which compels them to reincorporate into their practice and professional identity humanistic values. The theory represents a new addition to scholarship in medical humanities as well. It crosses the disciplinary divide by bringing together disparate systems of thought to elucidate the meaning of death as a seminal life event. The theory explains routine end-of-life encounters from medical practice with conceptualizations from the humanities: an intellectual marriage necessary to understand

death in its many dimensions, biological, legal, and ontological. In the humanities, the notion of the *kairotic* body contributes to scholarship in the related fields of material rhetoric and body studies. It opens to material rhetoric a new body to be theoretically fleshed out, so to speak. The *kairotic* body also expands upon conceptions of the grotesque and abject bodies. The corpse as *kairotic* body represents another *other* body that subverts social order; it is the unruly body that medicine ultimately cannot control. The *kairotic* body also serves as a means for the persons of living bodies to (re)construct their individual subjectivity and identity.

Limitations

The limitations of this dissertation are for the most part related to the scope of the study, which restricted the data I could draw upon to support the genre recognition of *perspective writing*. First, I limited my investigation of *perspective writing* to the subgenre of *necrography*, discourse specifically about experiences with dying patients and death. Second, I narrowed the range of texts examined to those authored by physicians about experiences from only their postgraduate medical training. Third, I collected and analyzed texts from only general medical journals.

I limited representations of *perspective writing* to texts and discourse from the subgenre of *necrography*, which I define as writing about physicians' personal encounters with patients as persons who are dying or already dead, with nearly and newly dead bodies, with death as an event, and with impressions or traces that remain after a death. While dying and death always have been a focus of medical education and practice, other issues have equally significant ethical and moral dimensions that produce

anxiety and/or distress and prompt physicians to respond discursively. Patients' decisions about controversial issues related to reproduction, for example, often conflict with physicians' personal values, resulting in moral discomfort. Families' surrogate decision making for patients determined to be incompetent can also pose ethical dilemmas for physicians who may reflect on troubling aspects of the situation over time. Thus, a wider inquiry into other topics broached in *perspective writing* is needed.

Another limitation was the narrow range of authors represented in the study corpus. Since *perspective writing* is a discursive response to medicalization and the hidden curriculum, I focused on discourse written by physicians-in-training or dealing with experiences limited to postgraduate training. Authors were primarily interns and residents who have received their medical degrees but have yet to complete their clinical training. They are not yet fully enculturated into the profession thus can provide perspectives on disquieting medical situations that are "raw" rather than seasoned. However, practicing and retired physicians, as well as medical students, also have published personal texts about their professional experiences in medical journals. The experiences of long-time physicians would be a valuable addition necessary for in-depth analysis of *perspective writing.* Likewise, I have limited *necrography* to physicians' personal writing. The subgenre and genre could be expanded to include discourse about personal end-of-life experiences of other health-care professionals. Nurses, social workers, and hospital chaplains frequently encounter dying patients and deal with death in their professional careers. Accounts of their experiences would add richness to *necrography* by providing additional perspectives on patient care at this stage of life. Other health-care professionals might also provide a significant contrast to what some

consider the dominant perspective of physicians.

Finally, the corpus for *necrography* is limited to texts collected from general medical journals focusing on primary care. Physicians' personal writing published in medical specialty journals also should be included to expand the corpus. Particularly salient would be perspectives on death from specialties, including oncology where practitioners expect a high rate of patient mortality, gerontology where the age of the patient population naturally raises questions of whether medical intervention is desired or likely to be effective, and palliative care and hospice where patient care focuses on quality of life in life-threatening situations and, in hospice, exclusively on end-of-life care.

Suggestions for Future Research

The most obvious areas for future research is expansion of the genre of *perspective writing* through a wider approach to authorship, identification of additional recurrent themes and subgenres, and inclusion of more medical journals. Other recommendations for research deriving from this study include development of a rhetoric of *necrography*, which would be useful in health communication, narratives studies, and medical humanities; an investigation into rhetorical silences in the subgenre of *necrography*, which would expand rhetorical theory; and further development of the notion of the *kairotic* body that would include an in-depth phenomenological analysis and an inquiry into end-of-life pedagogy through the philosophical lens of Jacques Ranciere.

Future research in *perspective writing* should examine personal experience narratives of physicians at all stages of training and professional careers. Medical

journals routinely publish articles by medical students, trainees, physicians in private practice as well as in clinics, private and public hospitals, physician-researchers, and retired physicians, all of whom offer unique perspectives on what it means to practice medicine. In the journal sections that feature physicians' personal writing, authors are usually identified with at least one sentence that describes their current professional position or standing, so an expanded bibliography of physician-authors would be relatively easy to compile. In a similar way, identifying other recurrent themes across the discourse would not be difficult, though it would be time-consuming. A useful tool would be the narrative analysis templates developed for this dissertation, which provide an analytic schema for comparing texts. Finally, *perspective writing* needs to be expanded in terms of the corpus; texts should be collected from medical journals beyond those focusing on primary care. Likewise, *necrography* needs to be expanded in terms of authorship and journal publication, as noted in the previous section on limitations of this study.

Another area of future scholarship generated from findings of this dissertation would be the development of a rhetoric of *necrography*. I identified 11 recurrent affective themes in the personal narratives of physicians-in-training. Using G. Thomas Couser's rhetoric of disability memoirs (2001) as a theoretical model, I envision investigating what these themes might reveal about societal attitudes towards dying and death, since trainees' perceptions still closely resemble those of the lay public. This research would extend scholarship in medical education and medical humanities. It would draw upon work in medicine and affect by Jodi Halpern (2001) in which she distinguishes between emotional reasoning, emotional thinking, and emotionality. It also

would incorporate recent work in affect theory (Gregg & Seigworth, 2010; Stewart, 2007) and extend that theory into medicine. By investigating the impact of physicians' emotional responses to dying and death upon public conceptions of death, this research would have the potential to help initiate a societal dialogue about death in the 21st century, an issue about which contemporary Americans are wary and generally fearful to confront.

Similar to society's denial of death is the silence that surrounds informal conversations as well as formal lectures in medicine about death and quality of life at its end. Thus, another rich area for rhetorical research is the identification and analysis of silences in *necrography*. Thomas Huckin's rhetoric of silence (2002, 2010) would be a valuable research tool with which to identify types of silence in physicians' personal discourse, determine whether they are benign or manipulative, and investigate what these silences tell us about attitudes toward death in the culture of medicine. His work uses critical discourse analysis, so it would be complementary to the work in this study. The project could draw upon other rhetorical theories of silence, including Adam Jaworski (1992, 1997), Cheryl Glenn (2004), and Maria Achino-Loeb (2006).

Finally, another area that warrants further research is the conception of the *kairotic* body. The theory needs more analysis and interpretation drawing upon the phenomenology of Maurice Merleau-Ponty and S. Kay Toombs (2001), and the work of Thomas Csordas (1994), who combines cultural studies and phenomenology and has been used in medical anthropology and in nursing. A project approaching the *kairotic* body from a different, though potentially valuable perspective for medical education would be an analysis using the theory of the emancipated spectator (Ranciere

2009/2011), a new understanding of perception using theatrical performances as theoretical scaffolding. The philosopher redefines spectators as vital, necessary participants in the truth of the theatre. He extends this notion of the spectator freed from passivity, alienation, and exteriority to pedagogy where the student or pupil becomes the "emancipated spectator" through a new perception of the interrelationship between vision, knowledge, and power. These ideas are relevant to medical education where surgery is "performed" in a clinical "theatre" and knowledge is gained through "medical gaze." Applying this theory of perception to the dead body could add yet another dimension to understanding how physicians and trainees perform at the end of life. One more related project would be to situate the *kairotic* body in body studies by discussing how qualities it shares as well as features that set it apart from Erving Goffman's notion of the stigmatized body (1963/1990); Mikhail Bakhtin's grotesque body (2005); Christine Harold and Kevin DeLuca's abject body (2005); and the (dis)abled body (Davis 1997).

These descriptions of future research projects are not inclusive by any means. Since this study builds upon and extends interdisciplinary research, scholars from other disciplines may find trajectories related to their interests at the intersection of medicine, health, narrative, death and dying, body studies, and rhetoric. I sincerely hope so, for the ways in which physicians find new meaning in their lives through intimate experiences with death hold promise for the public conversations Americans need to have in the very near future about how we die, so that we may live fully until then.

APPENDIX A

TEMPLATES FOR NARRATIVE ANALYSIS OF PHYSICIANS' PERSONAL NARRATIVES

NARRATIVE ANALYSIS

- **Dramatic narrative with scenes**
- **Narrative(s) embedded in piece**

INCLUDES:

- **Abstract:** summarizes story to come

- **Orientation:** introduces characters, temporal and physical setting, situation
  - **TIME – during night, call**

- **Complicating Action**
  - ***Pronouncing***
  - ***First experience with death***
  - ***Relative's death***
  - ***Deliver bad news***
  - ***Confronted with dying/dead body***
  - ***Confronted with medical futility***
  - ***Unexpected death***

- **Evaluation—**why it was told; what narrator is getting at; purpose; comments on narrative
  - **Internal attribution of evaluation to characters or state directly to self**
  - **External attribution—comment on story from outside**
  - **Embedded as extra details**
  - **Intensifiers—repetition** (like "real, real bad") (gestures, quantifiers)
  - **Explicatives—**appended to narrative or evaluative clauses
  - **Compare what happened to what didn't happen**

- **Result or Resolution—*Does it release tension? CLOSURE?***

- **Coda:** provides short summary; connects story with present; formulates point of story, consequences, "moral." Replaces Evaluation.

REVISED NARRATIVE ANALYSIS

- **Dramatic narrative with scenes**
- **Narrative(s) embedded in piece**

INCLUDES:

- **Abstract:** What is this about? summarizes story to come

- **Orientation:** Who, when, what, where? introduces characters, temporal and physical setting, situation
  - **TIME – during night, call**

- **Complicating Action(s)**—key event that disrupts equilibrium of expected circumstances
  For narrative pre—construction—related to unreportable event:
  - ***Pronouncing***
  - ***First experience with death***
  - ***Relative's death***
  - ***Deliver bad news***
  - ***Confronted with dying/dead body***
  - ***Confronted with medical futility***
  - ***Unexpected death***
  - ***Mistake***
  - ***Death in developing country***
  - ***Discussing code status***

- **Evaluation—**so what? why it was told; comments on narrative
  Types of evaluation:
  - ***Emotional/psychological***
  - ***Existential/Ontological***
  -
  - ***Professional/Social***

- **Result or Resolution—*Does it release tension? CLOSURE?***

- **Coda:** provides short summary; connects story with present; formulates point of story, consequences, "moral." Replaces Evaluation.

APPENDIX B

LIST OF ARTICLES COMPRISING THE STUDY CORPUS

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APPENDIX C

"NON-NARRATIVE" TEXTS: SIGNIFICANCE FOR THE CORPUS

Personal *Narrative* Versus Personal Experience

Five articles included in the study corpus of 125 articles do not qualify as narratives, but are significant in how they use language to convey their experiences. By default, these "non-narrative" texts illustrate the definition of *narrative* by showing distinctions between *statements* of personal experience used to structure arguments from *narratives* of personal experience. I reference two definitions of *narrative* elaborated upon in Chapter 6. A narrative is a sequence of events that make up individual's actual experiences usually recounted in the order in which they occurred (Johnstone, 2000, 2008; Labov & Waletzky, 1967). Personal narratives "imbue life events with temporal and logical order, to demystify them and establish coherence across past, present, and as yet unrealized experience'" (Ochs & Capps quoted by Johnstone, 2008, p. 155).

Narrative Recounts a Sequence of Events

Although the five articles *do* relate physician-trainees' personal encounters with dying patients and/or death, the authors do not recount their experiences as a series of events. Rather, statements about their personal experiences serve as "an abstract" (Labov, 2007, p. 48) of an experience that is used as a rhetorical claim, often as appeals to pathos and ethos. For example, a British physician recalls from his training, "One of my major hang ups was my own discomfort when dealing with dying patients and their relatives. In 1960 it was the norm to tell relatives and not the patient" (Gregory, 1983, p. 757). He does not follow up by relating an incident where he told family members that a patient was dying. Rather, the author continues: "This still happens but fortunately not as much as it did. The result is a ghastly betrayal of the patient-doctor trust." He then

describes "a formula" or series of questions he developed for geriatric patients with multiple health problems that he uses to "contract" with them, agreeing to treat only problems identified as essential to patients' desire to live. Statements about this physician's personal experiences, then, do not tell what happened; they support his principal argument: "I am not advocating euthanasia but something much better. Life before death can be fun" when "death [is] without hang ups" (p. 757).

In a similar manner, an American physician argues that autopsies should be performed on all patients, although he begins by conceding, "The first time I had to ask a family for autopsy permission drained me emotionally" (Feinberg, 1986, p. 67). He does not tell what happened before, during or after that initial encounter. He jumps to the present in the next sentence--"It still does and it doesn't seem to get any easier with time"—and offers reasons for his emotional response: an autopsy "…is final and not revocable and takes away a piece of each of us by its abrupt, chilling reminder of our own mortality" (1986, p. 67). Like the previous physician-author, Feinberg isolates a moment from his personal experience to appeal to readers' pathos.

A rhetorical appeal to ethos is exemplified in "Can I Cremate My Own Leg?" (Marlow, 1002, p. 774). The physician-author recalls two patients he treated during his training who wanted "their amputated leg[s] treated with dignity." He researches the topic and learns that "[a] patient may bury their leg themselves or burn it on a bonfire, but they cannot arrange for their leg to be cremated under their own authorization." Thus, statements of his personal experience do not relate what happened to the particular patients he introduced; they help establish the author as an empathetic physician-scholar.

Narrative Imbues Life Events With Temporal or Logical Order

In two other articles, physician-authors temporally and logically—though not sequentially--order events that comprise their personal experiences. In "The Inspiration of July," an attending physician reflects upon the summer month when trainees traditionally "begin their clinical lives with enthusiasm, wonder, and excitement" (Santoro, 1998, p. 111). The residents serve as annual reminders who "renew my faith in my profession, my specialty, and myself"; "I will teach you how to pronounce someone dead, but you enlighten me on the value of living life to its fullest each day." Thus, the attending incorporates the annual rotation of residents into his own professional practice through temporal order, imbuing meaning in an event that could be simply regarded as pro forma scheduling. He does not, however, relate a particular sequence of events that led him to integrate the annual rotation of residents into his own time frame.

Another emergency medicine physician reflects on his experiences after just completing a 3-year residency. To create meaning out of his list of myriad memories, he orders them associatively with the anaphoric phrase, *I learned that*… For example, "I learned that people die. Bad outcomes occur. And it does not mean you are a bad doctor or a bad person (though it might feel that way at the time). And the best thing to do is learn from it" (Prystowsky, 2006, p. 290). His statements imply that he experienced the death of a particular patient, though his recollections are described in general terms: "I learned that it is OK to feel bad when someone is hurt or when someone dies. And it is OK to come home and cry after a rough shift. It means that we are still human. And the day we are indifferent to pain and suffering is the day we should retire" (p. 290). Again,

the events recounted are not in themselves sequential, since we are not told they all relate to the same patient.

In summary, both emergency physician-authors "establish coherence across past, present, and as yet unrealized experience." However, their articles do not fulfill an essential requirement of a personal narrative: that it consists of a series of events.

APPENDIX D

UNIQUE PERSONAL NARRATIVES IN THE STUDY CORPUS

Unique Narratives in the Corpus

Four articles in the corpus are noteworthy for their unique narrative styles--a script for voices, fairy tale, utopian fantasy, and malapropism—which show how physician-trainees use narrative and narrative thinking to make sense of their clinical experiences. Not only do they reach outside the scientific world of medicine to find meaning in their practices, but equally important, they call into question assumptions about the certainty of medical knowledge, the validity of medicalization, and the powerful roles given to physicians: all components of the medicine's moral enculturation that is the hidden curriculum.

Script for Three Voices

"Innocent Bystander" (LaCombe, 1995), discussed in Chapter 5, is written as a script for three voices--a junior male intern, female senior resident, and female senior nurse—who each recount how a 45-year-old woman dies unexpectedly in the emergency room. They describe the actions each took, or did not take, in order to understand the death in which they are all complicit. The result is the narration of a sequence of events by multiple characters who each offer a personal perspective or, to use Genette's term, internal focalization (Herman, McHale, & Phelan, 2012, p. 301). Focalization also shows the distinction between the events that constitute the narrative—which are in the past and thus unknowable--and the narration of those events—which is all that can be known—that is referred to as "narrative discourse" in structural theories of narrative.[57] "Innocent Bystander," then, challenges medicine's claim of scientific truth as objective and

[57] See Gerard Genette's *Narrative Discourse* (1980).

knowable, for even three accounts from different perspectives cannot replicate what happened in the emergency room. All that can be truthfully accounted for is the discourse *about* the patient's death.

Fairy Tale

"Princess Abra" (Moorehead, 2008), also discussed in Chapter 5, initially seems to follow the structure of a fairy or folk tale. It begins, "Once upon a time, Abra and I met in the emergency room" (p. 80): an appropriate style for telling about Abra, a pediatric patient dying of a brain tumor whose only wish is to visit Disneyland. The article is a narrative, not a folk tale, however, for the characters do not fulfill the required functions of a folk tale according to structural theories of narratology. Specifically, the physician or "hero" character cannot save the patient or "princess" from cancer, the "villain."[58] Furthermore, after every narrative paragraph, the author inserts an evaluative clause: a one-sentence paragraph that comments on the narrative, addressing the reader as "you" and stating the meaning of the event just related. The conclusion of the narrative illustrates both of these points. After Abra's death, the physician writes, "This is when you hope for ever after" (p. 80). He inverts the standard fairy tale ending: The characters do not live happily ever after; only the readers' *hope* of eternity or an afterlife continues. Thus, the structure of "Princess Abra" resists traditional plots of medical narratives in which the physician cures the patient. It challenges the power attributed to physicians and calls into question the narratives of medicalization.

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[58] According to Vladimir Propp's morphology of folk tales (1968), characters fulfill specific functions in the narrative and thereby propel the plot. The folk tale's structure is based on action; characters are "actants" who serve 31 functions. The death of the princess is not one of the defined functions; the hero defeats the villain and marries the princess.

Utopian Fantasy

"The Anti-Emergency Department" is notable as the only utopian fantasy in the corpus. Although the definition of *narrative* I am using specifies that events actually happened, the fantasy is, according to the journal editor's note, "based on the author's experience as a second-year emergency medicine resident" (Green, 2002, p. 528). [59] The resident tells of 15 patients he encountered when "I dreamt I worked the overnight shift in the anti-emergency department." Each encounter is an inverse[60] of what an emergency medicine trainee realistically would experience: The 12 patients who live would have died. For example, "John was my next patient. He had turned 14 last week. His best friend was spending the night while his parents were away. John showed off his dad's loaded gun to his friend. They looked at it, practiced their 'hands up' routine, and put it away. Then they went and played some hoops" (p. 528). That the two teen boys, along with other patients, survived leads the author to conclude in the coda: "I could see the sun just coming up over the Atlantic from the top of the parking garage. I stood for a minute, marveling at all that doesn't happen in the universe…" (p. 529). *Marvel* means astonishment, which connotes something unbelievable, appropriate for a fantastical interpretation of the narrative. Yet, astonishment also can suggest confusion or bewilderment (*Webster's*). Thus, whether read as an imagined utopian fantasy or as the inverse of a trainee's actual experience, the coda tells readers that through narrative, the trainee is attempting to make sense of what can (not) happen in an emergency medicine

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[59] Jerome Bruner maintains that a narrative can be real or imaginary; "the sequence of its sentences, rather than the truth or falsity of any of those sentences" is what determines a narrative (1990, p. 44).

[60] "Inverse" should not be confused with "reverse," which has a very different meaning in Labov's narrative structure. To reverse means to change the order of narrative clauses and thus the meaning. If clauses can be reversed without changing the meaning of the sentences, they do not qualify as a narrative (Johnstone, 2008, p. 92).

department. Narrative functions as an alternative mode of thinking in medicine with which trainees can make meaning out of their (unbelievable) experiences.

Malapropism

On the other end of the emotional spectrum is "Early Learning," the only narrative in the corpus that uses humor consistently and subversively to challenge the authority bestowed upon physicians. A 1st-year emergency medicine intern is summoned to the hospital bed of a former patient who, by request, is being disconnected from a ventilator. His final wish, he writes on a yellow pad, is "to see his doc one last time" (Vander Leest, 2007, p. 88). The intern, "tremulous with sadness and amazed that the staff and family were waiting until I arrive before letting Joseph die," fights not to cry. When he sees the patient laughing, however, the trainee rereads the message and realizes the patient meant "his dog." The malapropism lightens the mood of the narrative's ending: "He mouthed the words 'thank you' to me. He died surrounded by his family, his dog, and his doc." More importantly, the malapropism enables the trainee-author to indirectly criticize the prominence often given to the physician's role at the end of life.

APPENDIX E

ANCIENT AND MODERN VERSIONS OF THE HIPPOCRATIC OATH

An Ancient Version of the Hippocratic Oath

This version of The Hippocratic Oath is from the National Library of Medicine's website on Greek medicine and credited to translator Michael North (2002) at the National Library of Medicine, National Institutes of Health.

I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgement, I will keep this Oath and this contract:

To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfill his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.

In purity and according to divine law will I carry out my life and my art.

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.

So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

Modern Version of the Hippocratic Oath

Many contemporary versions of the Hippocratic Oath have been made, which are used at medical schools during White Coat Ceremonies. The following is from the Johns Hopkins University Library website (Ruggles). The 1964 adaptation is credited to Louis Lasagna, academic dean at the Tufts University School of Medicine.

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

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